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Volume 63, No. 2

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The Operability of Carcinoma of the Stomach

• Edward C. Brenner, A.B., M.D., F.A.C.S., Associate Clinical Professor of Practical Surgery, the Post-Graduate Hospital (Columbia University), New York, N. Y.

THE operability of carcinoma of the stomach is dependent upon the surgical competency of the host and the extent and degree of the malignancy as evidenced by the lymphatic permeation of neighboring glands and organs or by more distant metastases.

Clinically, in a large number of cases, it is impossible to decide as to operability before the abdomen is explored. X-ray plates and fluoroscopic studies, the most valued diagnostic aids, do not rule out operability except perhaps in high cardia growths, whose definite fixation is demonstrated.

Likewise, a palpable mass does not interdict surgery. In August, 1933, a male, 50 years of age, presented a large palpable epigastric mass, the roentgenological studies of which showed a large filling defect in the pyloric antrum. The patient looked cachectic. Test meals showed achlorhydria with 12-hour retention and the blood a severe secondary anemia. Following blood transfusion, he was explored under novocain block, supplemented with gas-oxygen-ethylene anesthesia, and there presented a large colloid carcinoma without glandular metastasis or involvement of the serosa. An uneventful convalescence followed an easy gastric resection and the patient is well thus far with a better than ten per cent chance of cure. Thus the size of the tumor is no evidence of the degree of malignancy.

In contradistinction to this case, a patient of similar age, with indefinite dyspeptic symptoms, was explored the same day for a dubious filling defect. A small adenocarcinoma, but with metastatic glands and liver involvement, was found. In general, exploration is indicated unless there is evidence of metastases, fluid in the abdomen, fixation of the growth to the abdominal wall, or jaundice. Cases with a hemoglobin below 60 or a red blood count below 3,000,000 should receive preliminary transfusion.

Upon exploration much can be elicited by careful inspection: the presence or absence of fluid, of peritoneal implants, especially in the pelvis, or of fat necrosis in the mesentery or omentum indicating pancreatic involvement. Very fine fibroid nodules in Glisson's capsule should not be mistaken for metastases. After the mass is palpated and its mobility evaluated, a careful search is made for metastatic glands, for nodules in the liver, or pancreatic involvement. Edema about the mass or about metastatic nodes connotes a rapid carcinomatous lymphatic permeation with accompanying lymphangitis and should interdict radical excision. Such cases all die of cancer and many leak if resected.

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Another group, which taxes the ingenuity of the surgeon, is made up of those cases in which the mass is adherent to the pancreas with questionable hard nodes in the mesentery. Is the growth ulcer or carcinoma? When in doubt, a gland may be removed for frozen section or the stomach may be opened and a section of growth be removed with the cautery for immediate biopsy. If the evidence favors ulcer, a gastrojejunostomy should be performed and resection, if necessary, done at a later date. If the evidence points to carcinoma, a resection is performed by many surgeons, even in the presence of small liver metastases, as the patients, though incurable, are rendered more comfortable. In cases where a mass is easily resectable, although the diagnosis of malignancy is questionable, resection should be performed.

Gastric resection for early growths, in which there is no edema and in which only the gastric

Presented at the Post-Graduate Hospital (Columbia University) in connection with the 7th Annual Graduate Fortnight of the New York Academy of Medicine, October 31, 1934.

wall is involved, offers better than ten per cent of permanent cures. The mortality of such resections in thin patients is no higher than that of cholecystectomy. Fortunately, the vast majority of gastric carcinomata occur in a resectable site, namely, the distal two-thirds of the viscus. Growths high in the cardia are technically more difficult of approach and usually involve the esophagus or are adherent to the diaphragm at the time of operation.

The majority of cases coming to the surgeon are far advanced; either nothing can be done or only a palliative short-circuiting gastroenterostomy to relieve obstruction and to divert the food stream away from the growth, thereby lessening irritation. I prefer the antecolic long loop operation with supplementary enteroenterostomy. It is simpler; it can be performed under local anesthesia and the anastomosis can be made farther from the pylorus than in posterior gastrojejunostomy. In no case have I found normal posterior gastric wall where there was no available normal anterior wall.

Of the resectable cases, the disease is not curable in much more than ten per cent, as in the majority cancer cells have permeated into the pancreas or into the liver or into the lymph glands beyond the zone of possible resection, or cells have been carried by the lymph or blood stream to other organs, later developing metastases. Local recurrences due to infiltration of the pancreas or neighboring lymph nodes or metastases to the liver predominate as the cause of death in the cases in which resection was possible.

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The chief problem today is early diagnosis and not one of surgical technic. The laity should be educated to seek medical advice for any digestive disturbance that is more than ephemeral and the profession must be alert to investigate very carefully every case of so-called indigestion. Gastric analyses and stool examinations for occult blood are adjuvants in diagnosis but careful x-ray studies, both by plates and the fluoroscope, are the chief aids in early diagnosis.

When the results are even suggestive of gastric pathology, a prompt exploratory laparotomy should be advised. The danger under novocain block, supplemented with gas-oxygen-ethylene anesthesia, is negligible. We believe spinal anesthesia is safer than inhalation anesthesia unskillfully administered.

It is only in early malignancies localized in the stomach wall that resection offers a fair promise of cure. Failure to recognize this early operable stage is the most formidable hindrance to successful treatment. X-ray therapy for gastric carcinoma is valueless. Retention, achlorhydria, palpable tumor, loss of weight and cachexia are time-worn criteria of advanced pathologies. The clinician must be prepared to suspect and diagnose carcinoma in the absence of all of these.

14 East 68th Street.

The secret of cancer treatment is to discover it early. There are only three safe methods: surgery, radium and X-rays.

The Practitioner of the Future

James B. Herrick, Chicago (*Journal A. M. A.*, Sept. 22, 1934), points out that whether a physician is to be successful depends in a measure on his native endowment and to some extent on chance. The possessor of knowledge, even though it is accurate and encyclopedic, is not necessarily a good practitioner. The reason may go back to the man's choice of a vocation. Some men are not medically minded. There are those who think that success as a practitioner will come only if much time is devoted in undergraduate and later years to research. Medical research and practice differ in qualifications of workers, in objectives and in methods. The aim of research is to advance knowledge by discovery of the new. Practice is the application of knowledge already known. Every question of diagnosis is for the clinician a research problem. Unless the physician is inspired by the activating curiosity to know, to find out by close observation, by comparison with his own experience and that of others, by use of laboratory aids or by experiment, he is an inefficient practitioner, non-progressive and doomed to failure. Too implicit reliance on laboratory examinations may cause sound clinical judgment to shrivel up from disuse. Besides, unless there is extreme watchfulness, the laboratory may develop the impersonal in the doctor at the expense of the personal. The true physician must possess a dual personality, the scientific toward disease, the human and humane toward the patient. The physician learns by study, he becomes proficient by experience. He profits by his own mistakes and those of others. The patient is the most valuable text-book for the undergraduate student and the graduate doctor. The lower schools, universities and professional schools are seriously concerned with what is the best preparatory course for the doctor. How may fewer but better doctors be trained? If good and efficient service is rendered by the ordinary practitioner as an individual or as a member of a group there will be fewer quacks, fewer cults, fewer semi-charitable organizations supported, or even run, by philanthropically minded laymen or recalcitrant physicians. The graduate of today, while he may know relatively less than the doctor of fifty years ago is, absolutely, far better informed than his predecessor. The practitioner realizes that he must know still more. He is eager to learn. The hard work in the local society in order to be most effective should be done more by members and not so much by invited guests. The status of the practitioner will be determined largely by what he himself does rather than by what is done for him by others. What he gets out of practice will be in proportion to what he puts in. A result of this personal effort on the part of the doctor will be that he will become more self confident, will lose some of his inferiority complex. His patients will sense this and go to him as of old for advice or for treatment. He will dare of himself to test a knee jerk, to assess at its real value a heart murmur, even to tell whether tonsils should come out or stay. He may possibly be so thorough as to make a rectal examination and courageous enough to pass judgment on the results, thus depriving the consultant of one of his cherished prerogatives and most fruitful sources of income. Specialism and research are necessities and have come to stay. And so has the practitioner; but only when, as, and if, he is qualified. There will surely develop in the future a competent practitioner, who, with integrity of character, with ideals of medicine as a profession and not a trade, with mind well stored with knowledge, with skill to apply this knowledge in a large proportion of cases of disease, with consciousness of his limitations, with readiness and ability to advise when and where expert help may be obtained, with good judgment and keen powers of observation sharpened by experience at the bedside and at the necropsy table, is worthy to be the family doctor or adviser, with all the traditional privileges and rewards that come from the personal relation of the old time doctor with the family —esteem and high standing in the community, the confidence and affection of his patient.

Most of us should study medicine instead of economics.
—*Lancet.*

Acute Suppurative Arthritis of the Sacro-Iliac Joint: Case Report

• Otho C. Hudson, M. D., Hempstead, N. Y.

WE ARE reporting a case of acute primary purulent arthritis of the sacro-iliac joint because a search of the literature reveals few cases reported. Our case was diagnosed only at autopsy.

The literature deals almost entirely with secondary purulent arthritis and with chronic destructive lesions of the joint.

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Case of R. M. boy, age 13 years, who was admitted to Nassau Hospital on July 28, 1934.

The chief complaint was pain in the region of the right buttock. His present history began nine days ago when patient rode a bicycle twenty-five miles. Four days ago he had sudden pain in the region of the right buttock. This increased in severity until any motion was painful. He has had a temperature for the past forty-eight hours. There is no history of any recent infectious diseases.

Family history revealed mother and father living and well. Past history revealed pertussis and mumps as a small child. Five years ago he had a fracture of the shaft of the right femur.

Physical examination revealed the temperature 104, pulse 100, and respirations 26. The blood pressure was 120/50. Patient was a well developed and well nourished boy acutely ill. Skin was hot and dry. Head, eyes, ears, and nose were negative. Throat was injected. Tonsils were small. Heart was of normal size with second pulmonic sound greater than the second aortic sound. A rough systolic murmur was heard at the base. It was more distinctly heard at the pulmonary area. Electrocardiogram revealed sinus tachycardia. Lungs were clear to percussion and auscultation. Abdomen was soft and no mass or tenderness was felt. Rectal examination was negative. The reflexes were normal in the upper and lower extremities. Extremities were all negative except in the right gluteal area. There was a loss of the gluteal cleft, and fullness of the entire gluteal area. There was tenderness over the ilium and posteriorly along the gluteus maximus muscle. The white blood cells were 15,700, polymorphonuclears 78%, small lymphocytes 22%. Blood culture taken on 7-28-'34 revealed two colonies of *Staphylococcus aureus* on 7-31-'34.

A diagnosis of acute osteomyelitis of the right ilium with gluteal abscess was made and an operation performed.

•

At operation under general anesthesia an incision about seven inches long was made parallel with the gluteal fibers, the muscles were split and dissection was carried downward to the ilium. The ilium and hip joint were explored and no pathology in the soft tissues or bone was found. A culture was taken from the gluteal area next to the bone. A few superficial skin sutures were placed in the wound. The culture revealed *Staphylococcus aureus.*

An x-ray of the pelvis showed the right sacro-iliac joint to be normal. There was definite obscuration of the left sacro-iliac synchondrosis, the margin of which could not be made out definitely. There was some rotation of the pelvis, so that the findings might have been partially due to distortion plus overlaying soft tissue and gas in the colon.

On 7-20-'34 the temperature was 104. Patient was seen by Dr. Wilfred M. Post in consultation in the morning and in the afternoon. During this period abdominal tenderness developed, especially in the right lower quadrant. Patient had some spasm and cried out with pain on the rebound test. Rectal examination was negative. There was dulness and a sense of resistance above the pubis, possibly due to a full bladder. Appendicitis and general peritonitis of the primary type were considered. Sutures were removed from the gluteal wound. Swelling and tenderness about the hip were unchanged.

On 7-30-'34 the temperature was still 104 and over. Patient was seen by Dr. Benjamin W. Seaman, Dr. Wilfred M. Post, and Dr. William L. Sneed in consultation. It was believed that the patient had some definite intra-abdominal condition with a general peritonitis.

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At operation by Dr. Wilfred M. Post, under general anesthesia, the abdomen was opened with a right lower rectus muscle-splitting incision. On opening the peritoneum a large quantity of serous fluid was noted. The intestines were somewhat inflamed. The appendix was located retrocecally on the medial side of the cecum and presented the same appearance as the surrounding intestines. The appendix was removed. Further examination revealed an edematous and boggy right psoas muscle mass just anterior to the promontory of the sacrum. With a large needle the retroperitoneal space just below the boggy area was aspirated. No free fluid or pus was demonstrated. The abdomen was closed. Cultures taken from the abdomen were sterile.

On 8-1-'34 the temperature was above 104. Patient refused food by mouth and was given intravenous saline and glucose. Blood culture showed an increased number of staphylococcic colonies. Wound was clean and there was no discharge.

On 8-2-'34 another blood culture taken showed

eleven colonies of *Staphylococcus aureus* per CUBIC centimeter. Temperature remained above 104. Pulse rate and respirations were rising.

On 8-3-'34 there was still motion in the right hip without pain. There were still no symptoms referable to either sacro-iliac joint. The right gluteal area was aspirated in a number of places without results. No focus of pus was found. Three hundred cubic centimeters of whole blood were given by transfusion.

On 8-6-'34 the patient was much worse, and cyanotic at all times even with oxygen. The temperature was above 105. Breath sounds were suspicious of some changes over his lungs. He rapidly failed and expired.

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AUTOPSY REPORT by Dr. Lawrence Sophian:

The peritoneal cavity reveals diffuse injection of the surface and some cloudy fluid collected in the recesses, especially in the pelvis. There is necrosis and some pus in the anterior wall, and fresh, fibrinous adhesions join the cecum and small intestinal loops to the region of the abdominal incision. The margin of the true pelvis presents a purple, dull, bulging surface. There is fibrin on this, and when the peritoneum is pulled away thick, creamy pus exudes from the iliopsoas muscle. A cavity is found in this muscle which is explored with the finger and is found to run alongside the sacrum and posteriorly under the spine of the ischium into the deep muscles of the buttock. Another cavity runs above the sacrum, between that bone and the fifth lumbar vertebra, and the muscle in all of this region is soft and infiltrated with thick pus. The periosteum is stripped off the sacrum and the adjoining part of the ilium. The sacroiliac joint is seen to have eroded edges anteriorly and is freely movable, with a hemorrhagic interior surface. The bone of the ilium appears firm throughout in this region, whereas the sacrum presents a porous, reddened surface and a spongy consistency. About two hundred cubic centimeters of pus were evacuated at various parts of the broken down muscle and cellular tissue. Pleural cavities appear normal. All other organs normal.

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DIAGNOSIS, Anatomical: Acute suppurative arthritis of the right sacro-iliac joint.

Acute cellulitis and abscesses of iliopsoas and lumbar muscles, with subperitoneal infiltration, and acute fibrinous peritonitis.

DIAGNOSIS, Microscopic: Confirmed the diagnosis of acute osteomyelitis and purulent arthritis of the sacro-iliac joint.

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This case is of interest because of the negative operative findings due to the mistake in diagnosis. There was a total lack of symptoms referable to the sacro-iliac joint at all times, although the later abdominal symptoms should have made one suspicious of this possibility. The few cases in literature describe the pain as referred to the hip, without limitation of motion. There were abdominal symptoms always present. The patient also had pain along the sciatic nerve due to irritation. It is quite possible that a greater number of these cases are seen than are reported, as the virulence of the infection causes death before nature gives definite localizing symptoms. The subacute and chronic lesions of the sacro-iliac joint are often difficult to diagnose unless the x-ray findings are definite.

The cases give intrapelvic collections of pus and drain externally by diverse paths. The form of therapy is that recommended by Kulowski, which is the Bardenheuer-Picque resection of the ilium. This treatment was indicated, as proven by the post-mortem findings in our case. The simple opening of the sacro-iliac joint by the Smith-Peterson method, as for a fusion, could not drain any of the intrapelvic abscesses, although it would partially drain the joint proper.

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CONCLUSIONS:

An undiagnosed case of acute suppurative arthritis of the sacro-iliac joint is reported.

It appears that primary acute sacro-iliac lesions are rare.

The diagnosis of acute lesions of the sacro-iliac joint is difficult to make.

Radical resection of the ilium is indicated for drainage of this joint.

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Professional Building.

Proud Father, 85, Claims Record with 35 Children

(AP) Dispatch from Dedham, Mass.—No one we know would want to mussolin on his record.

What the profession needs is more medicine and better medicine. Physicians on the relief funds, as a rule, have been preparing for it for several years.

Keith Motion Picture Honored

A motion picture in natural colors, taken in the technical research department of the Keith Hospital for Plastic Surgery, has been awarded the first prize at the scientific exhibit of the American Society of Cinematographers. Exhibitors from all parts of the world participated. The subject of the picture was Plastic Reconstruction of the Deformed Nose.

Lung Fixation In Severe Bronchiectasis

• Edwin J. Grace, M.D., F.A.C.S., Brooklyn, N. Y.

SOME of the modern methods suggested for a cure of severe cases of bronchiectasis have been so very disappointing in the hands of the Kings County Hospital Staff that we are reporting two cases in which lung fixation and phrenic paralysis did not produce the results that we hoped might be accomplished.

•

CASE I—J. C., age 44.

Chief Complaint—Cough and expectoration of eight months duration.

Past History—Patient was well until June, 1933, when he started coughing. In July of the same year he had severe pains in the left chest and became very weak. He was admitted to a hospital elsewhere, where he started expectorating considerable greenish sputum. Pain disappeared in October of the same year but he developed pain in the left foot; could not dorsiflex foot and a diagnosis of left foot drop was made. Cough and expectoration persisted until he was admitted to Kings County Hospital. In February, 1934, there was profuse, foul, greenish sputum.

Laboratory Findings—In March, 1934, x-rays with lipiodol showed bronchiectasis of left lower lung, although tuberculosis of left upper lung could not be excluded. All laboratory studies, except a moderate anemia, were negative.

Operative Procedure—In March, 1934, lung fixation of the 7th rib was done under local anesthesia. In April, 1934, the phrenic nerve was crushed for a distance of 5 mm. Immediately after the operation the patient gained four pounds and the sputum diminished by about one-half. There was an average of about 400 c.c. before the operation and the amount averaged 200 c.c. soon after the operation. This very encouraging picture began to change until by May, 1934, the clinical picture was essentially the same as before the operation. During this month the patient attempted suicide by cutting his throat and wrists. Emergency treatment controlled the immediate problem but the patient died in four days.

Autopsy Report—Cause of death: Bronchiectasis—operated; chronic myocardius; chronic organizing pneumonia; chronic nephritis.

Contributory—Incised wound of throat—attempted suicide.

Histological Data—Lungs: Organizing pneumonia; anthracosis; bronchiectatic abscess; chronic passive congestion (brownish induration of lung).

Kidneys—chronic focal glomerulonephritis.

In examining this lung at autopsy, this type of bronchiectasis was seen to be undoubtedly in the group which would be classed as very severe. Although we had obtained lung fixation and a phrenic paralysis it seemed difficult to believe that this type of surgery could cure cases of severe bronchiectasis.

CASE II—C. O., age 48.

Chief Complaint—Constant cough and expectoration of foul smelling sputum and occasionally blood; weakness and poor appetite.

Past History—One year ago was operated on for gastric ulcer which she had had for three years. Gall-bladder and appendix removed at same time. One month postoperative she developed pneumonia and pleurisy; ever since has been coughing and upon slight exertion expectorates blood.

Physical Examination—Negative except chest, which showed numerous coarse râles at right base posteriorly and in the mid-axillary line. Clubbing of finger tips.

Laboratory Findings—x-ray studies with lipiodol, done in March, showed evidence of saccular bronchiectasis throughout entire one-third of right lower lung field. All other laboratory studies, except a moderate anemia, were negative.

Operative Procedure—In April a lung fixation was done. Iodine gauze packed under one rib, no. 7, one space above bronchiectatic area. Two days later the packing was removed as the patient was having respiratory difficulty. Sputum lessened considerably. Patient seemed improved. Later that month a right phrenicectomy was done, crushing the nerve for about 8 mm. The patient's general condition was much improved after the operation and sputum was greatly lessened. Toward the end of the month the condition was fair but the sputum had begun to increase again. By May the sputum was back to the original amount, and a compression of the diseased lung was attempted. Ribs no. 6-7-8 and 9 were exposed; periosteum removed and a rubber dam and washed iodoform gauze packed beneath ribs; reaction during the operation was good. Pulse never above 120; of good quality. Toward end of operation patient vomited a moderate amount of foul smelling pus similar to sputum she had been raising. She was returned to the ward in good condition, but about fifteen minutes after returning she became pulseless and cyanotic in spite of all forms of artificial respiration and stimulation. She died about one-half hour later.

Diagnosis—Bronchiectasis—Right lower lung. Lung Abscess—Right. Acute Myocarditis.

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In the *Journal of Thoracic Surgery,* Herbert reported the results in three cases of bronchiectasis greatly benefited or cured by fixation of the lung and phrenic paralysis. Our results in two cases suffering from bronchiectasis do not permit me to share his optimism in curing this condition. Archibald, in a recent meeting of the American Association of Thoracic Surgeons, suggests a classification of bronchiectasis into mild, moderately severe and severe types. Using this as a workable rule it would seem that the excellent results obtained could be easily brought about in mild or moderately severe cases. However, severe cases require more radical surgery than the procedure of lung fixation, phrenicectomy or lung compression.

121 Fort Greene Place.

From the Surgical Service of Dr. Edwin H. Fiske, Kings County Hospital, Brooklyn, N. Y.

Complications of Peptic Ulcers—Their Prognostic Significance

SARA M. JORDAN and EVERETT D. KIEFER, Boston (*Journal A. M. A.*, Dec. 29, 1934), state that obstruction, hemorrhage and intolerance to alkalis are complications that influence prognosis in the medical management of duodenal ulcer. Obstruction of all degrees in the group of seventy-nine cases that they studied was relieved in 89 per cent by medical management. It recurred later in 13 per cent. Obstruction, hemorrhage and intolerance to alkalis were all unfavorable factors in the medical management of the disease. Single hemorrhage had the least effect on prognosis; obstruction was next in its unfavorable influence; multiple hemorrhage and intolerance to alkalis had the most harmful effect on the later course of the disease.

The Organization of a Cystoscopic Clinic

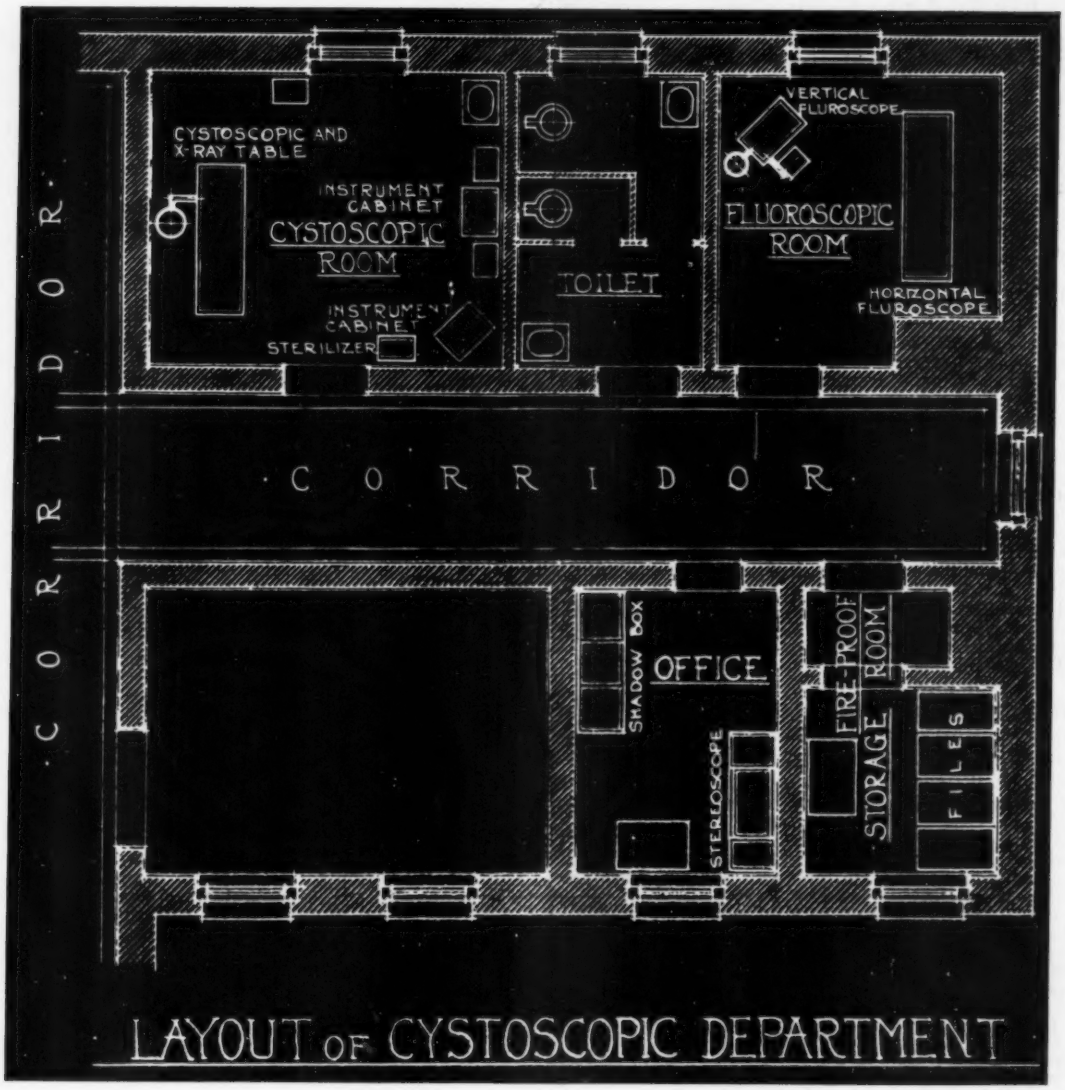
• Henry H. Morton, M.D., F.A.C.S., Chief of Urological Service, St. Peter's Hospital, Brooklyn, N. Y.

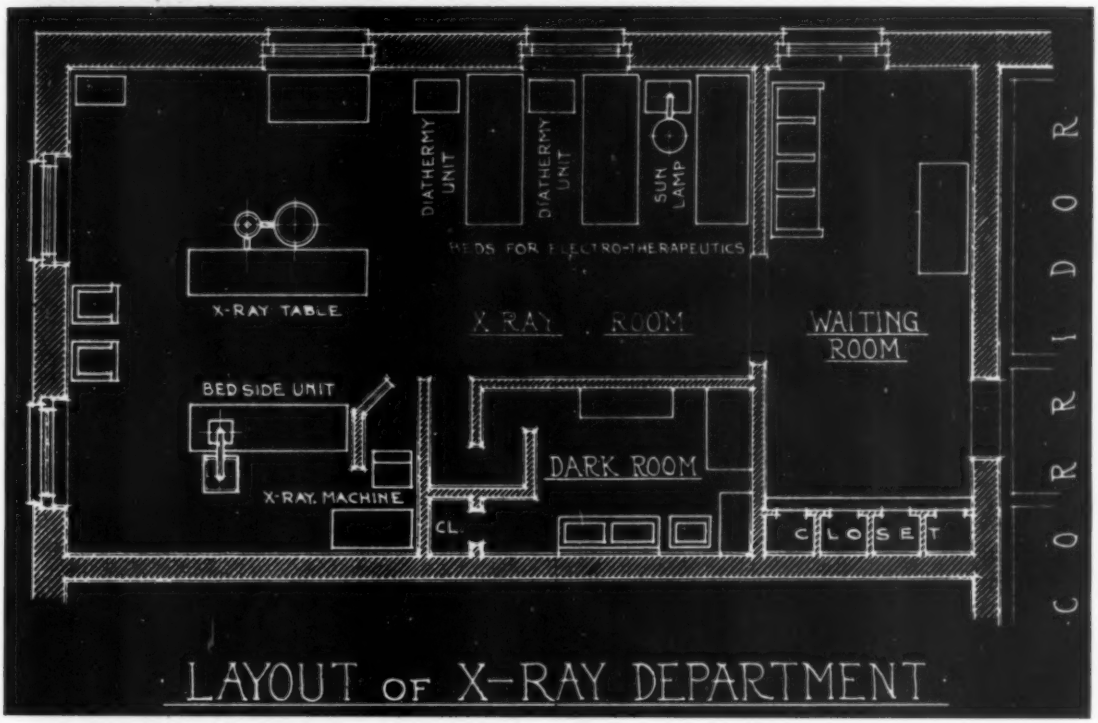
THE great importance of radiofraphic study of the kidney, combined with pyelograms and ureterograms, has been appreciated by both physicians and urologists, but this has been especially true of the past ten years.

The internist is constantly meeting with patients suffering from pains in the abdomen or flank, paroxysmal or constant in character, which may be due to appendicitis, disease of the gall-bladder or vertebrae, or to abdominal malignancy, on the side of the purely medical conditions, or which may originate in the kidney.

To mention the principal causes of pain originating from the kidney we may cite renal calculus, ptosis of the kidney with a bend or kink of the ureter, obstruction of the outflow of urine through the ureter, resulting in hydronephrosis, adenocarcinoma, hypernephroma of the kidney, tuberculosis rarely except in the closed form, and disease of the ureter, such as impacted calculus or stricture obstructing the outflow of urine.

For a proper differentiation of these conditions it is usually impossible to make a diagnosis by palpation alone and, consequently, we have to call upon





LAYOUT OF X-RAY DEPARTMENT

the aid of the x-ray, cystoscope and ureteral catheter.

Until the combination cystoscopic tables provided with the Coolidge tube and Bucky diaphragm were brought out, a pyelogram was often a very cumbersome procedure. The cystoscopic room where the ureteral catheters are introduced in most hospitals is usually on the top floor of the hospital, and the x-ray machine is generally located in the basement. This makes it necessary after the ureteral catheters are introduced to lift the patient onto a carriage, wheel him to the elevator and, after his descent into the x-ray room in the basement, to place him upon the x-ray table, inject the pelvis of the kidney and take a pyelographic picture. After this procedure he is again lifted onto the stretcher, and then taken up on the elevator to the ward. Is it any wonder that after such an excursion a strong reaction and rise of temperature often follow?

The importance of x-ray and pyelograms induced urologists to devise a table for cystoscopic and x-ray examination at the same time and, in most hospitals, with a little planning a room can be found on the same level and adjacent to the x-ray room.

The Sister Superior of St. Peter's Hospital, realizing the importance of the avoidance of unnecessary handling of patients in our cystoscopic and pyelographic examinations, provided the quarters shown in the illustrations for the Urological Department several years ago and we have found them most satisfactory in their working.

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In all x-ray examinations of the abdomen the greatest obstacle to getting clear pictures is the accumulation of gas in the colon. When this is extreme, the view of the kidneys is so obscured that the organs cannot be seen. Many attempts have been made to do away with this nuisance, but no measure is always entirely satisfactory. The plan which has succeeded best with us is as follows:

The night before the examination the patient is given compound licorice powder, one dram. The day of the examination the patient receives a cup of black coffee only for breakfast, and in the forenoon a high enema, followed by a colonic irrigation, is given. The patient is given a glass of water every hour until three glasses have been taken, so that we will be sure to have some urine flowing out of the kidneys after the catheters have been introduced. A hypodermic of one-quarter grain of morphia is given a half-hour before the examination. The patient is placed upon the above-described cystoscopic table, the bladder viewed and the catheters carried up to the pelvis of both kidneys. After the flow of urine is established on both sides, the right and left urines are collected in test tubes and sent to the hospital laboratory for examination, which comprises a search for pus, crystals, and bacteria, and eventually a culture or guinea pig inoculation may be made when necessary. When the urinary secretion is seen to be well established, indigo carmine is injected intravenously and the time of appearance of the blue coloration noted. The appearance time in a normal kidney is usually from five to six minutes, whereas a notable delay in the appearance of blue urine on one side denotes disease of that kidney. After testing the urinary function with indigo carmine, a flat x-ray

(Concluded on page 43)

Nasal Hemorrhage

• Irving Wilson Voorhees, M.S., M.D., New York, N. Y.

IT WAS a dark and stormy night in mid-January. A little group of doctors accustomed to foregather for an informal evening in each other's homes had finally dispersed, and this narrator had "turned in" for much needed rest. The telephone rang. O pest! Twenty minutes of sleep and then this. But the watch showed 2.30 a. m.!

"Hello! Yes! You say you have been trying but cannot stop this nasal hemorrhage? How long have you tried? For four hours? Adrenalin helps for an hour and then you have to go at it again? All right, I'll run up and see what I can do."

No cars were in sight, and, of course, no taxi, when going out into the dread chill, but the walking distance was only about ten blocks, and so, with the heavy ulster collar high about my neck, and the little black bag always kept properly stocked for emergencies, with reminiscences of seeing the old country doctor go off on just such errands decades ago, and trying not to feel too sorry for myself, I sallied forth.

Elevators do not run in all apartments after midnight, and so there were five flights to go. Middle-age adiposity had not as yet burdened the bearer with too much avoirdupois, therefore the climb was not difficult. The doctor was waiting at the head of the stairway, and seemed very glad to share the responsibility with another phvsician.

Entering the bedroom, I found a woman of 35 years moaning and roaming about the bed with very evident signs of beginning air hunger. The place was a shambles, and everything available, from sheets to shirts, had been used as a sop for blood. A history could not be obtained from the patient, but some one stated that she had undergone a nasal operation about a week previously, that she had visited her specialist during the morning of the day in question, that he had "put some wires" into the nose which immediately caused bleeding, and that this bleeding had grown worse constantly up to the time I was called. A disturbing feature was that she had telephoned this specialist, asking him to visit her at her home, and that he had flatly refused, telling her to "put some iced cloths on the face and neck." The seeds of a malpractice action had been well planted, and agile sidestepping of pointed questions gave me some troublesome moments. Just what kind of operation had been performed, neither the patient nor her friends knew. "It was just a nose operation, that's all." Blood was still dripping steadily from both nostrils, and large clots were frequently expectorated. Since submucous resection of the nasal septum is one of the commonest of all nasal operations, I assumed that it had been done in this instance. Therefore, it was necessary to clean the nose as thoroughly as possible, locate the flaps, remove all clots from between them, and try to secure coaptation. In my bag there was a bottle of hemostatic serum. This was swabbed into the nose between the flaps, outside the flaps and in every possible direction, particularly in the region of the anterior blood vessels where they enter the nose through the bony foramina in the hard palate. The flaps were then held in place by a "flap speculum," and Simpson intranasal tampons were placed in the anterior nares. These were promptly soaked with water from a medicine dropper, and as they expanded, the bleeding stopped. After 24 hours, the family doctor was asked to remove the splints, and the patient made a happy recovery under tonics and good general management. A few weeks later I received a letter from this patient's lawyer asking me to appear against the surgeon, and it was only after much argument that he and the patient were persuaded to defer legal action. The suit was never brought. The surgeon is dead and I do not think he ever knew why the threat against him was not carried out.

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Following is a typical case of nasal bleeding which had nothing to do with trauma, surgical or other.

An excellent physician, practicing in the suburbs, called for help about 10.30 one night. He said that one of his patients had been bleeding from the nose for two days "on and off." Several times it was, apparently, stopped by means of iron styptics, and adrenalin and cotton plugs, only to start up again in a few hours. The family were becoming rather unmanageable, and were clamoring for a specialist. Arriving at the home, there seemed to be no tangible cause for the original bleeding attack. The gentleman spent much time in his cellar, which he had fitted up as a *weinstube*, and he was very proud of his prowess as an amateur brewer. As a rendezvous for friends, the place was ideal and was much appreciated by them, but the householder did much of the drinking himself. Moreover, he was a good deal of an epicure, although one might use a more unkindly word, and spent considerable time seeking out stores which sell unusual and "special" kinds of cheese, bread, etc. At any rate he was in bad shape. The pulse was very rapid and thready, the skin of ashen hue, and he had the urge to make frequent trips from his bed to the bathroom, where he passed large "tarry" stools. The locus here was easily found to be at the anterior area of the septum where the septal artery passes upward from the floor of the nose. Pledgets of adrenalin and cocaine were held against the septum until one could get a clear view. Then a bead of chromic acid was fused on an applicator and the area was touched but *not scrubbed* with this bead. Vaselin-gauze strips were packed snugly against the area on both sides, were removed in 24 hours, and healing was soon complete. The patient was asked to return to his physician for the taking of blood pressure and general study, but refused to do so at first.

He then told me that he had "seen" his physician and that everything was all right. And so I dismissed the case from my mind. But two years later, another physician chanced to tell me in general conversation that he had the patient under his care for a right-sided cortical hemorrhage with corresponding paralysis of the left extremities. In this instance, as so often happens, nasal hemorrhage was a warning of high blood pressure, something like a governor on a steam engine which permits a "blow-off" of steam and reduces the pressure, thus preventing an explosion. In every spontaneous nasal hemorrhage, one should be suspicious of high blood pressure. Every such case should be promptly turned back to the internist for management, and there our responsibility as rhinologists ends.

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Just one more citation to illustrate what can happen. An "oil man from the West" was taken with a spontaneous hemorrhage in his hotel room while visiting New York. The hotel physician, after several attempts, was unable to do more than check the bleeding temporarily, and he sent the man to my office. There was a superficial artery on the left side of the nasal septum, anteriorly. This bled rather profusely when touched, and so it was cauterized with chromic acid in the usual way, followed by vaselin dressing. But within a few hours, the man called me and said that the bleeding was troubling him again. At the second visit, I cauterized the right side, *unwillingly*, since cauterization of both sides within a short time is likely to produce a septal perforation. The next day, he 'phoned again, stating that the bleeding was as bad as ever. I then sent him into the hospital and, under cocaine anesthesia, dissected up the flap on the right side and crushed the blood vessel with an artery clamp. This procedure, described by the late Dr. John Leshure, has often proven valuable to me. The bleeding stopped for two days, and the patient was about to be discharged when he developed an acute rhinitis with yellow discharge. At my request, the house surgeon irrigated the nose with normal saline. The patient was told not to breathe, but became confused, breathed in rather suddenly and aspirated some of the washing. He coughed rather violently, and the irrigating was discontinued. Within two hours he "shot" a high temperature, developed a severe chill and pain in the side, and in about thirty hours died of a massive fulminating pneumonia! The reader can imagine the amount of explaining that was required to satisfy the family, and all by long-distance telephone. Since this unfortunate happening, I never see an irrigation given without dread of a possible fatality. Pneumonia must be rare in such instances, but experiences of this kind lay heavy upon the heart of every physician. They seem to be a sort of penalty imposed upon us by "whatever gods there be" in order to humble the doctor in the dust. But I feel that we can all profit greatly by them, harrowing though they may be. Experience is indeed our first teacher, but the tuition which she levies upon us often comes too hard.

140 East 54th Street.

The Organization of a Cystoscopic Clinic

(Concluded from page 41)

plate is taken with leaded catheters in the ureters, to show the size and position of the kidneys or any shadow in a pelvis or ureter. The pelvis of the suspected kidney is then injected with sodium iodide solution, using a small syringe and ceasing the moment the patient complains of pain. The quantity of solution which the pelvis holds is noted, as if it is much in excess of 8 c.c. it is evident that a degree of hydronephrosis is present. A plate is then taken after the pelvis is filled, and the catheter partly withdrawn from the pelvis so that it lies in the lower ureter. The ureter is then injected with sodium iodide through the inlying catheter which has been partly withdrawn, to determine if any kinks, bands or dilatations are present in the ureter. In exceptional cases a fourth plate is sometimes taken after three minutes, to determine the time required for the pelvis to empty itself after withdrawal of the catheter. The plates are at once developed and looked at while wet in the shadow-box. The following day, after drying, the plates are read and the findings noted on the history by the hospital roentgenologist.

With such a complete study of the urinary tract nothing in the way of pathology can be overlooked, and we consider each of the steps described as being of value in making a diagnosis.

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Occasionally the necessity of a pyelogram of each kidney for the purpose of diagnosis occurs. On account of the danger of suppression of urine, we never make double pyelograms at the same time, but wait a couple of days before making the second pyelogram.

The importance of not making a double pyelogram at the same sitting was forcibly impressed upon me in another hospital when, after a double pyelogram, complete suppression of urine followed and lasted forty-eight hours, but eventually the urinary flow was re-established and the patient recovered.

We have used uroselectan intravenously in a few special cases, but I feel that in ordinary patients whose ureters can be catheterized we get better pictures by catheterizing the ureters and injecting the pelvis from below. Of course, in the presence of impermeable ureters or in patients in whom for any reason, such as contracted bladder; persistent bleeding, or great pain, cystoscopy is impossible, uroselectan may give us the necessary information and has a certain advantage in showing a simultaneous picture of both kidney pelves and ureters.

While these notes contain nothing of any novelty, the writer feels that a report of our experiences may be of some help to other general hospitals where similar work is being carried out.

32 Schermerhorn Street.

Eczema in baby, followed by recurring bronchopneumonia at 4 to 7; hives at 10, hay fever and obscure intestinal allergy in later life.

Special Article

Lewis Stephen Pilcher, M.D., A.M., LL.D.

• James P. Warbasse, M.D., Brooklyn, New York

DR. LEWIS STEPHEN PILCHER represented that rugged quality in medicine that characterized its practitioners in former days. His ancestry was the pioneer British stock that came to Virginia in the early part of the eighteenth century, migrated to Kentucky, and thence to Ohio and the West. His father was a Methodist clergyman on the frontier of Michigan with a tremendous thirst for knowledge. He was a member of the Bar and took a degree of Doctor of Medicine at the age of forty-nine, while carrying on a multitude of duties connected with his pastoral work. Lewis Stephen, born July 28, 1845, studied at his father's knee. He entered the University of Michigan at the age of thirteen. He took his bachelor's degree at seventeen. His master's degree was added within a year. At the time of his death, on December 24, 1934, in the ninetieth year of his age, he was still the youngest to have matriculated and the youngest to have graduated at that university.

Immediately upon his graduation he entered the medical school. Then came the Civil War. He served as a hospital steward, returning to Ann Arbor to take his medical degree in 1866. He first engaged in practice in a country district in Michigan where he taught the rural school at the same time. He rode his horse across the countryside to the call of the sick, his saddle bags stored with medicines, dressings and books. He read extensively, followed the medical literature of the day, and for diversion perused the classics in their original Greek and Latin.

Soon followed an internship in the Detroit Hospital, a post-graduate course in the hospitals of New York City, and an appointment as Assistant Surgeon in the United States Navy. For five years he sailed the seas, studied men and cases, continued to read widely, and contracted yellow fever in Havana. He entered private practice in Brooklyn in 1872 and, to expand his knowledge, organized a dissecting room in the upper floor of his home on Monroe Street. Here he had private classes of young men eager to learn more about the human body. Out of this group grew the Brooklyn Anatomical and Surgical Society, in 1878, with Pilcher as its President. That was the beginning of organized scientific surgical discussion in Brooklyn. The Transactions were first published in a volume bearing the date 1878-9 as the ANNALS OF THE ANATOMICAL AND SURGICAL SOCIETY.

The succeeding volumes appeared as the ANNALS OF ANATOMY AND SURGERY, a monthly publication under Pilcher's editorship. This continued till 1884, when the editor went to Europe to study surgery. Upon his return the publication was continued as the ANNALS OF SURGERY. This was the first surgical journal in the English language. Pilcher was its founder and editor. He continued to occupy this position for fifty-one years. Including the original Transactions, he was a surgical editor for fifty-eight years; and at the time of his death he probably had had the longest period of medical editorship of any editor in the world. A galaxy of medical editors have been born, studied medicine, served long periods of editorship, and died, while Pilcher sat at his editorial desk.

The leaders of the Methodist Church called upon him when the Methodist Hospital, in Brooklyn, was first considered. He was the dominating medical authority in its organization and construction. It was his vision and genius that made it a notable medical center. He was the dominating medical personality from its founding in 1882 until 1907. To this institution he gave the twenty-five best years of his life.

In his long career, he taught anatomy at the Long Island College of Medicine; he was professor of surgery at the New York Post-Graduate Medical School; he was surgeon to the Methodist Hospital for twenty-two years, surgeon to the German Hospital and later established a private hospital as the solution of his own hospital problem.

It can be said to the credit of the medical profession that it has always esteemed its men of excellence—sometimes late, but usually during their lives. Dr. Pilcher was no exception. His worth was recognized as soon as he entered medicine. His colleagues saluted him always as a leader in thought and action. His sterling character won for him the homage of men.

He was in time president of The Kings County Medical Society and of the American Surgical Association. The honors that came to him were earnests of his merit. In 1916, the semicentennial of his practice was celebrated by a public banquet. This was attended by three hundred and fifty guests, among whom were many of the leading figures in his profession. On this occasion he was presented with a massive gold medal, made for the occasion, a silver replica of which is deposited in the Metropolitan Museum of Art. A *Festschrift* surgical volume was issued in his honor at the same time.

Lewis Stephen Pilcher was a strong man. His character made its impression upon every institution he touched. He stood for honesty and high standards. His influence upon the medical profes-

sion in his community has been of enormous service. He was not only the advocate of high standards in the art and science of medicine but he went out and did hard work for their enforcement.

He gave his best efforts to the Methodist Hospital and planned for its development. But he would not compromise. His resignation from its staff and from its Board of Directors came in 1907 with unequivocal vehemence in protest against methods of which he disapproved. This he accompanied with a resignation from the church.

His religious training and background influenced his conduct. His morals were puritanical. He had little patience with the erring. His attitude was often dogmatic and sometimes obstinate. His intransigeance was severe. A politician he never could have been. He was well aware of his deficiency in the talent called diplomacy. There was no question as to where he stood. His opinions were expressed in language that had meaning and power.

When he severed his Methodist connections, his religious sentiment expressed itself in patriotism. He gave much time to the veterans of the Civil War and interested himself in the Great War. For this gentleman of superior mental gifts, scholarship and culture to find companionship with the followers of Mars always seemed an anachronism. His superior qualities, however, saved him from war blindness. He at least accorded to others the right to refuse to be swept into military insanity. He displayed conspicuous free-mindedness in defending the persecuted from war hysteria.

His writings were masterful. His textbook, THE TREATMENT OF WOUNDS, appeared in 1883. He published many papers on surgical subjects, essays, and addresses. His charming autobiography, A SURGICAL PILGRIM'S PROGRESS, tells the story of the growth of a man. It is a straightforward and revealing document.

The lack of a sense of humor cost him much. He could not see himself in others whose conduct he criticized. And the predicaments of life were to him rarely amusing, but either serious or stupid. He cared neither for music nor the drama, and derived no fun from the sports. In his later years he became less austere. He read much contemporary literature and made himself well informed on present-day thought. He did much to rid himself of the wishful thinking that burdens other minds.

As his one-time intern, as his assistant for many years, and as his colleague and friend for a period of over forty years, I have seen his influence upon his profession to be both far reaching and beneficent. This is because he radiated a quality which refused to compromise with mediocrity or sham. He wanted things right. He respected good work and reverenced scientific methods. His life was a struggle toward perfection.

In that struggle, his career was full of events which he himself had made to occur. He was not the passive man; he compelled things to happen. In expanding his own life, he enriched the lives of others. He left a fine tradition of excellence for his profession to prize.

Cineradiography

AT a special meeting of Fellows of the Royal Society of Medicine held on May 1st, DR. RUSSELL J. REYNOLDS gave a demonstration of a practical method of X-ray cinematography. The President, Mr. V. WARREN LOW, took the chair.

Dr. Russell Reynolds recalled that in 1897 Dr. John MacIntyre, of Glasgow, had shown the moving bones of living animals. His own first experiments had been made in 1921. Methods, he said, must be simple, expeditious, and inexpensive if they were to come into general use. There were two means of taking rapid serial radiograms: the direct and the indirect. The former being very costly, he had directed his attention to the indirect method, in which an ordinary cinematographic camera was used to take photographs of the shadow cast on a fluorescent screen. The three essential conditions were: a sufficiently brilliant image, cutting off the unwanted X-rays from the film and ensuring that the subject was not exposed to an excessive dose. Only recently had technical improvements made it possible to obtain satisfactory records of the viscera. Fortunately the lens itself proved to be sufficient protection against direct rays, and it was only necessary to protect the camera with lead. The patient could be protected by synchronising the working of the X-ray tube with the movements of the camera shutter. A total exposure of 16 seconds to one area had been given and repeated, and no ill-effects had been noticed. Dr. Reynolds showed lantern slides of the synchronising apparatus and the general lay-out, and gave details of the technique. The method was simple enough, he said, to be worked in any hospital or consulting room, and the apparatus took up very little room. The film was non-inflammable so that no special fire precautions were necessary. The image could be projected normal-sized or enlarged. It was unnecessary in practice to have a long length of film; a short piece could be made up into a band and run continuously through the projector. In this way cases could be studied at leisure. The exposure need only be long enough to obtain a record of the movements desired; in most cases this could be done on a piece of film a foot or more long in a very few seconds. The resulting negative could be printed off again and again on a length of positive film. The expense of production with a 16 mm. film was small.

Dr. Russell Reynolds considered that the method should prove of immense value in investigating lesions of the lungs and pleuræ, especially after lipoidol injections or artificial pneumothorax. There were obvious advantages, too, in being able to study indefinitely movements in pathological states of the alimentary tract. In orthopædic lesions the range of movement in joints could be observed and progress watched. The permanent records could be used in diagnosis, to watch progress or the effect of treatment, to send to other physicians for information or a second opinion, and for teaching purposes. The value of radiology in elucidating anatomy was well recognized; radio-cinematography would do much to reveal the function of the organs, notably the heart.

Dr. Russell Reynolds then took a film on the platform, where apparatus was set out for inspection. The film was developed and shown at the conclusion of the meeting. A series of beautiful human films was demonstrated, showing movements in joints, the process of deglutition, the movements of the stomach and intestines, the action of the heart and aorta, respiratory movements of the diaphragm and ribs, and finally the modified, laboured action of some pathological hearts.

Dr. R. JANKER (Bonn) said that he had cinematographed small objects only by the direct method, at a rate of 22 exposures a second. He showed lantern slides of his apparatus and technique, and then a series of films. The first was the thoraces of a rabbit and a cat showing respiration and heart action in normal breathing and in single and double pneumothorax. The effects of carbon dioxide were shown, and the pulsation of the bronchi demonstrated by filling them with opaque substance. Some interesting pictures showed opaque injection into the femoral vein, its rapid passage to and through the heart, and the formation of emboli in the lungs. Striking films of gastro-intestinal movements in animals followed.

Economics

Department Editor: THOMAS A. MCGOLDRICK, M.D.

Labor Looks At Medicine

• Matthew Woll, Third Vice-President, American Federation of Labor, Washington, D. C.

IN the evolution of medicine from a superstition to a science there is something of a parallel development with the evolution of labor from slavery to the status of freemen. Both measure the advance in man's history. But there is something more that is akin in the long history of medicine and of labor. It was the same power of science applied to industry which set in motion the industrial revolution which, when applied to the early practices of medicine, brought changes both in practice and procedure that were no less revolutionary in character. I speak as a layman, but I wonder if the advent of Darwin's scientific method in the middle of the nineteenth century did not change the whole course of medicine both as a profession and as a healing art.

For, prior to the introduction of the scientific method in medicine, the only groups professionally interested in the patient were the physician and the pharmacist. With the development of science and the growth of medical research a new series of inventions of apparatus appeared. Medicine had its technological revolution. And yet each new invention in equipment served to carry adequate medical care just a bit farther out of the reach of the average individual. For example, the physician of a century ago, in order to reduce a fracture, needed only a knowledge of anatomy and a sense of touch and sight. With the development of the x-ray, however, a new world of medicine was opened; diagnosis became positive. But what is more, medical care called for this new machine, and the new machine called for greater capital investment at additional cost to the patient.

The parallel with industrialism is striking in terms of invention, but the results appear to me quite different. In industry the general trend of research has been directed toward a reduction of cost of commodities; in medicine the trend has been in the opposite direction—to increase the cost of service. Apparently it could not be otherwise. The point in all this is that, so far as labor is concerned, adequate medical care is out of the reach of the average individual, especially in the low-income group. This consequence comes not as any fault of the doctor, or of the average individual; but rather, the cause lies in medicine itself. For illness is unpredictable, and being unpredictable illness cannot be included in the wage earner's budget. And yet it constitutes a larger proportion of the wage earner's annual expenditure than any other element. When, furthermore, one adds the wage-loss to the cost of medical care per year for this group, it reaches well over half a billion dollars a year.

There is, moreover, a deeper attachment of labor to medicine, which is that intimate relationship of patient and practitioner. It is personal yet widespread. Labor, which has borne the physical burden of the world, has also borne its grief, harbored much of its disease, and frequently paid the price with its life for its ignorant neglect of the symptoms of illness.

It is this heritage of labor's experience that prompts me tonight to speak on the topic "Labor Looks At Medicine" or, probably more accurately and less academically, "Labor Looks At the Doctor." Let me begin by asserting what I believe to be a universal conviction—that what labor wants the world over is not wealth or power, but health. That is the supreme desire. With it all things are possible; without it labor, however large numerically, is nevertheless impotent. Health is labor's capital. It is an asset greater even than skill of eye or hands; for without health even the skill of workmanship is of little value. For this reason labor has sought to restore health when wracked with disease and to provide protection as well as prevention against disease as a part of the social cost of conducting industry.

Let me be specific. The hazards of industry are many and they grow more numerous. They range from accidents and disease to old age and now we count unemployment as included in this list. Long before the state and the public generally recognized the existence of these hazards, however, labor had through the limited resources of its own unions sought to provide relief for the victims of these hazards. Indeed, the germ of the whole movement of social insurance is to be found in the beneficiary features of the trade unions. But the limitation of such resources was apparent as well as the danger to the health of the community in having so great a company of workers outside of the trade unions subjected to occupational hazards without some adequate provision. The effort to universalize such provisions for all workers is part of the purpose of the movement for social insurance.

But labor in its advocacy of such social legislation has been realistic in outlook and in its tactics. It has led the advance, but it has not lost contact with the forces which mold public opinion. It is now more than 25 years ago that labor began its crusade for workmen's compensation laws. The first law passed in this country was, in fact, sponsored by William Green, now President of the American

Address before the Second District Branch of the Medical Society of the State of New York, at Garden City, November 15, 1934.

Federation of Labor, and passed by the Ohio State Legislature, of which he was then a member. Since then labor has urged and secured the enactment of compensation laws in 44 states of the Union. It has championed improvement both in standards of administration and in coverage of such legislation.

Of recent years labor has come to recognize that the form of this law has an equal importance with the purpose of the act. In particular it has sought the enactment of Exclusive State Funds for accident compensation. The basis for that position I set forth some nine years ago at a public hearing in the Senate Chamber of the New York State Legislature. It has a bearing on our discussion. May I quote from my brief on that occasion:

"We claim that an exclusive state insurance fund presents the following advantages: lower cost to employers; improved benefits to workmen; higher benefits or a lesser accident cost to the workmen.

"We hold that premiums should be paid in claims for injuries received, rather than be used for payment of profits; that premiums paid should in part provide for accident prevention work.

"Our present competitive system now represents an economic waste, instead of human conservation.

"The exclusive state insurance fund will provide a more prompt payment, a more liberal enforcement of the law, lessen appeals and delays, stimulate greater contentment and satisfaction, provide immediate help to those in need and intended to be helped when injured in industry, and make for an improved industrial relationship between employer and worker.

"We would rather see the burdens lessened upon the employers who are required to provide this insurance, and the benefits to the wage-earners enlarged, than profits created for private insurance companies.

"We know the removal of delays, the lessening of appeals and the elimination of Shylock methods now prevailing will make for a happier, a better, a more contented and a more cooperative relationship between employers and workmen."

There remains this important conclusion. And it is important that the medical profession recognize the fact that in the judgment not only of labor, but of many other students of social legislation, the administration of workmen's accident compensation would be greatly simplified under an exclusive state fund.

In recent months a question arose in this state about the medical aid amendments to the Workmen's Compensation Act, as a result of a report of a special committee appointed by Governor Lehman. The proposed legislation arising out of the report sought "to permit the injured worker to have greater freedom in his selection of a physician, to make more uniform the present competitive element of medical cost for services rendered by doctors, and to secure the interest and efforts of the organized medical profession in regulating and controlling the conduct of its own members and carrying out the medical care and treatment required under the compensation law." Without going into a detailed discussion of this report and recommendation labor believes that if the medical men would give more attention to improving the Medical Practice Act it would be unnecessary for them to be so concerned with the Compensation Law. There is, of course, chicanery connected with the law, but the old question is pertinent: is the remedy better than the disease? Frankly, labor, as I see it, and especially the injured worker, did not stand to benefit much from such a proposal. Furthermore, the medical costs would be greatly increased.

I speak of this recent concrete case as another reason for closer collaboration between the medical profession and labor in the formulation of a program which will alike protect the worker's interest, the doctor's professional standards, and the general public interest.

In addition to the provisions for an exclusive state fund, labor has long urged an all-inclusive coverage of occupational diseases. It is not many years since we were all shocked by the lingering deaths that came to the girls who were employed in painting the luminous dials of watches with a radium paint, in the neighboring State of New Jersey. The disabilities which arise out of occupational disease are, as you know, very serious. Is there any reason why a worker who is incapacitated from an occupational disease should not be compensated as well as those who suffer injury in the course of employment? The travesties of justice which one might cite provide an emphatic answer in the negative. Labor not only stands four-square for the inclusion of all occupational diseases in a compensation program, but would point out that the added cost would not exceed one per cent; the moral value would be many times that amount. Here is a case where, if I may speak as an official of labor, the members of the medical profession who are concerned in the promotion of health could join with labor in bringing this desideratum to pass.

In more recent months there has been a widespread discussion of the significant findings of the five-year study of the costs of medical care. Such discussions have been actively carried on by the members of the medical profession and I am told that not all doctors agree on the action which should follow this monumental report. Speaking in behalf of the low-income group in the community, who must remain without adequate medical care because they are without adequate income, may I say that more than sixteen years ago the New York State Federation of Labor, after a careful study, submitted a bill for health insurance to the State Legislature. It was an attempt in this country to provide adequately against the toll which illness takes of wage earners in the land. This early bill provided for medical benefits such as surgical and medical treatment, supplies, and nursing for the insured worker and the dependent members of his family, and hospital treatment and dental care for the insured worker. It was directed at elimination of the ambulance-chasing physician who has been a burden comparable with the ambulance-chasing lawyer. Cash maternity and funeral benefits were all provided in the bill. Private insurance companies were expressly excluded from consideration.

Trade unions, through voluntary action, have made attempts in the past to provide forms of health insurance. While their actions may be regarded as purely experimental and have proven, in most in-

stances, inadequate, yet they have been productive of much good. But the burden of taking care of workers who are ill and providing for them adequate hospital and medical service is altogether too great to be borne by these voluntary organizations. Besides, as a rule, those who need help most are those who fail to avail themselves of the benefits offered.

Why should the working people themselves bear this financial burden? There is no good reason why the care of the sick, the aged, and the disabled among the working classes should be borne by the working people alone. Industry and society at large should both be required to bear their share of this burden. It has been stated by eminent men who have given this subject much thought and who have investigated the matter carefully that a very large percentage of working people become permanently incapacitated because of lack of proper medical attention when ill. Even when the disability is not permanent, the illness extends over unnecessarily long periods of time for this same reason.

Inasmuch as each worker is a social unit, society is vitally interested in promoting and maintaining at the highest standard the efficiency of each worker. Loss of time, inability to work, and the removal of each social unit from the field of industrial activity mean, in the last analysis, a distinct loss to society at large. Looking at the matter from this point of view it is clearly obvious that society is benefited by promoting and preserving the health and vitality of each productive social unit. With a vast body of social experience in England and in Germany to draw upon, America is rapidly becoming conscious of the need for this form of social legislation.

During the reconstruction period following the World War, American labor, in pursuit of its traditional philosophy, turned to the development of economic organization and to high wages to supply the necessary margins for protection against the hazards of disease. They provided, if not wholly adequate safeguards, at least a measure of insurance against illness. But with the coming of the depression and the breakdown of wage standards and with it of living standards, the scene changed. Labor's share of a much diminished national income was inadequate for such an emergency. It turned to the field of social insurance with a new awareness that as disease has ceased to be an individual concern alone, so health and its promotion was the interest of the community; and that while treatment must be individual, the concern of society in the right of everyone to adequate medical treatment was a paramount concern. So labor has turned again to health insurance with a conviction first expressed a decade and a half ago and now re-expressed in the light of the experiences both of prosperity and adversity through which it has passed. At the 54th Annual Convention of the American Federation of Labor, which has just adjourned in San Francisco, that great parliament of American labor went on record by resolution in favor of a study of health insurance by the Executive Council and indicated in the report that such a study was not only appropriate, but needed. I do not presume to prejudge such a study, but it is my judgment, based upon labor's past position and its development of an exclusive program of social insurance, that it will make health insurance an indivisible part of its program.

Labor, looking at the doctors, wonders how these practitioners of medicine will react to such a proposal. Some, I surmise, will dissent and others support the proposal. May I suggest that if you will look at this problem through labor's eyes, through the eyes of those who speak for the low-income group in our midst, you will be bound to conclude that the issue in America has ceased to be an academic issue. We face a fact, not a theory. As labor by the sheer logic of events was compelled to change the process of its reasoning to meet the new situation, so the doctors must alter in many cases the pattern of their thoughts to face the new day.

But whatever point of view may ultimately prevail, labor finds itself in full agreement with the President when, in commenting upon the subject of health insurance in his security address of yesterday, he said: "Whether we come to this form of insurance soon or later, I am confident that we can devise a system which will enhance and not hinder the remarkable progress which has been made and is being made in the practice of the profession of medicine and surgery in the United States."

Finally, labor regards it a sad commentary upon our time and present plight—that year by year health appropriations have been reduced and hygienic service has been progressively curtailed. Fundamental health protection has thus been decreased during a period when the economic depression has presented a very grave and serious matter to many families with and without incomes—and in addition has created new hazards to the health of our people—all of which tends not only to enlarge the present unfair burden but to increase this unfortunate load now being shifted more and more upon the shoulders of the medical profession. By the same token the medical profession is to be highly commended for the great service being rendered in a time of extreme national urgency and emergency.

Labor, I repeat, seeks health. It seeks to protect its members from disease; to restore those who are afflicted. To achieve this goal it will use all of its instrumentalities to provide adequate medical care for all, and it will not only solicit but welcome the healing and helping hand of the medical profession.

Indications for Therapeutic Abortion from the Standpoint of the Neurologist and the Psychiatrist.

CLARENCE O. CHENEY, New York (*Journal A. M. A.*, Dec. 22, 1934), reviews some of the opinions of neurologists and psychiatrists on therapeutic abortion and reports a number of specific cases of mental disorders, involving the question of abortion, from which he concludes that: 1. There appears to be no individual neurologic or psychiatric disorder that is an absolute indication for abortion in women suffering from such disorders. 2. Experience shows that some women with severe advanced neurologic disorders may go through pregnancy and have healthy children. 3. Experience shows that some women suffering from severe mental diseases may pass through normal pregnancy and childbirth. 4. Experience shows that abortion does not necessarily prevent a recurrence of mental attacks or bring about recovery from attacks already existent. The pregnant woman's general physical condition must be given careful consideration in a decision regarding the termination of pregnancy.

Fourth International Hospital Congress in Rome 5th.-12th. May, 1935

The International Hospital Association announces that the Fourth International Hospital Congress will be held in Rome from 5th.-12th. May, 1935. The Italian Government is making the necessary arrangements in collaboration with the chairman of the I. H. A.

Participation in this Congress is earnestly recommended to all Public Health Departments and to all Associations, institutions and individuals interested in the architecture, technical equipment or administration of hospitals.

The Congress will be opened on Sunday morning, May 5th., and several papers from different aspects will be presented for discussions by leading experts on each of the following subjects:

1. The Hospital as a link in a systematic Public Health Service.
2. The Equipment and Technical Appliances of the Hospital.
3. The function and protection of the Hospital in times of national calamity.
4. The importance of each main group of Hospital Staff with regard to the relations of the Hospital to the Community.

The afternoon of the 5th., the whole day of the 6th. and the 10th. of May will be reserved for meetings of the permanent international study committees. A detailed program of these is being published in the first number of Nosokomeion (the quarterly review of the I. H. A., published by W. Kohlhammer, Stuttgart) for 1935.

The Congress will be preceded by a study trip through the larger cities of North Italy and followed by a study or pleasure trip through South Italy, Sicily and Tripoli. A detailed program of the Congress, including particulars of these trips, will be published in the fourth number of Nosokomeion.

All particulars regarding the Congress can be obtained by writing to the Bureau of the I. H. A. (Address: Cantonal Hospital, Lucerne, Switzerland).

Surgeons to Meet in Jacksonville, Florida

The Southeastern Surgical Congress, through its secretary, Dr. B. T. Beasley, announces the sixth annual assembly of the Congress which will be held in Jacksonville, Florida, March 11, 12 and 13, 1935. The Congress has met previously in Atlanta, Birmingham and Nashville.

The states composing the Congress are Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee and Virginia. A record attendance is anticipated at the Jacksonville meeting. Since March is the most desirable month to visit the land of flowers many surgeons will no doubt combine business and pleasure and attend during this season of the year.

Some of the most distinguished surgeons in the country representing the different surgical specialties have been invited to appear on the program. A partial list of those who already accepted places is as follows: Doctors Walter C. Alvarez, Perry Bromberg, Hugh Cabot, Willis C. Campbell, George W. Crile, John F. Erdmann, Paul Flothow, Ralph Green, Arthur Hertzler, C. Jeff Miller, Alton Ochsner, J. C. Patterson, J. Knox Simpson, J. W. Snyder and W. A. Weldon. More than twenty others will be listed when the program is completed. Look for the completed program which will be mailed about February 15, 1935.

For information address Dr. B. T. Beasley, Secretary-treasurer, 1019 Doctors Building, Atlanta, Georgia.

Emergency Relief Practice

Physicians made 17,000 calls on sick people among the families receiving home relief from the City of New York during November, 1934.

These physicians were paid by the city's Emergency Relief Bureau and were sent only to those homes where investigation showed that the family could not afford to engage the services of a private physician.

At present there are approximately 3,000 physicians on the list available on call to render services when needed.

In November, 1933, there were 107,379 families receiving home relief care throughout the five boroughs, and during that month 4,890 visits were made to the homes of sick persons, while in November, 1934, there were 212,357 families on home relief and 17,033 calls were made by physicians.

Besides the doctors available on call, twenty-five nurses are doing full-time duty with the destitute sick on home relief, and other nurses from the various nursing services are engaged in part time work. The calls for nurses are under the supervision of Miss Ruth Lavin, and the cooperating nursing services are Henry Street, Brooklyn Visiting Nurse Association, North Shore Public Health Visiting Nurses Association, and the Staten Island Visiting Nurses Association.

Not only nursing care is given by the relief nurse on her visit, but also instruction on care of the patient.

Any person on home relief is entitled to the home medical care if he is unable to secure necessary medical attention otherwise. The system is now working smoothly and efficiently, and persons on Home Relief applying for medical care are usually receiving expert attention as speedily as if a doctor had been called privately.

Tribute Worth Having

(Schenectady Union Star)

In the hall of the School of Tropical Medicine at San Juan, Puerto Rico, stands a bust of the late Dr. Bailey K. Ashford, the army surgeon who relieved Puerta Ricans of the scourge of hookworm.

Dr. Ashford died some six weeks ago. Every morning since then, his bust has been found banked with flowers—big bouquets and little ones, many of them in strange, little home-made native jars. No one knew who put them there; so at last a watchman was appointed to keep an eye on the bust all night long and see what happened.

He found that poor folk from the country were tramping in to town each night with their arms full of flowers to lay at the feet of their benefactor—the one tribute they could pay to the man who had done so much for them.

Men who have served humanity have won many kinds of memorials, in different times and places; but was there ever one more beautiful or expressive than this?

New Biologic Test for Hormones in Pregnancy Urine

A. E. Kanter, C. P. Bauer and A. H. Klawans, Chicago (*Journal A. M. A.*, Dec. 29, 1934), place a previously standardized fish in a two quart bowl containing 1 quart of water at about 75 F. The fish is observed to make certain that the oviduct is not beyond normal limits. Four cc. of the urine to be tested is put into this water. The fish is observed at intervals of twenty-four hours. If the test is found to be positive after the first twenty-four hours the test is discontinued; if negative, it must be carried out for seventy-two hours before a definitely negative report may be given, in spite of the fact that about 80 per cent of the positives were positive at the end of the first twenty-four hours. Normally the oviduct is about 2 mm. in length and reaches less than half the distance to the end of the ventral fin. With a positive reaction the ovipositor reaches past the edge of the ventral fin or to a length of 15 to 25 mm. After the test is completed the fish is put into a tank for recovery and left for from two to three weeks in order to allow for the regression following the positive reaction. It may then be used for other tests. At the outset the authors deemed it advisable to run the fish tests parallel to Friedman tests in order to determine the relative merits of the two. To date they have thirty-one such tests, with twenty-seven absolute checks and four discrepancies between the two tests. Tests were also made on five ectopic pregnancies, proved at operation, which were all positive but which had not been checked against the Friedman test.

Cancer

Department Edited by JOHN M. SWAN, M.D. (Pennsylvania), F.A.C.P.

EXECUTIVE SECRETARY, NEW YORK STATE COMMITTEE OF THE AMERICAN SOCIETY FOR THE CONTROL OF CANCER

Assisted by CHARLES WILLIAM HENNINGTON, B.S. (Rochester), M.D. (Hopkins), F.A.C.S., *German Literature Editor,* and UMBERT CIMILDORO, A.B. (Cornell), M.D. (Rome), *Italian Literature Editor.*

Cancer of the Prostate

CARCINOMA of the prostate is one of the less frequent forms of carcinoma. In New York State in 1933, in 16,924 cases of death from cancer and other malignant tumors, 676 were recorded as due to cancer of the prostate, or 3.99 per cent. (10) These figures are based on the cause of death item on the death certificates, many of which are clinical diagnoses and erroneous. McCarthy and Kramer (5) are of the opinion that cancer forms about 18 per cent of all prostatic lesions. On the other hand, Young (7) found 460 cases of carcinoma by microscopic examination out of 4,295 glands removed surgically at the Brady Institute (10.7 per cent). Young admits that if he had included in his figures those cases in which a clinical diagnosis was made followed by treatment with radium, in which no microscopic study was done, the percentage would be higher. Dillon (8) reports thirty-one cases. Of these nine were definitely diagnosticated before and proved malignant after removal; twenty-two were clinically questionable. Of these twenty-two nodules, nine were reported malignant by the pathologists; that is, nine malignancies out of twenty-two clinically questionable growths (40.9 per cent). The pathologist reported six of these growths as precancerous and seven as chronic prostatitis with hypertrophy. Ferguson (12) tabulates the results of the examination of 1738 prostates gathered from the literature. Among these 200 (11.5 per cent) early or borderline cancers were found. Watson (18) reports 411 cases of carcinoma of the lower urinary tract. One hundred and ninety-four of these were carcinoma of the prostate (47.2 per cent).

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SYMPTOMS: Carcinoma of the prostate may develop without giving rise to symptoms (Young, 7; Barringer, 13; Muir, 14) until obstruction or evident malignant metastases invite the attention of the patient or his physician. However, O'Crowley, Trubek, and Goldstein (4) point out that in the two cases which they report, sciatic pain was the first symptom. Bugbee (1) says that the sudden onset of urinary retention, following the existence of apparently innocuous urinary symptoms, may be the result of malignancy. Young (7) gives the following list of symptoms which should lead the physician to be suspicious of prostatic carcinoma and which should demand proof of the absence of malignancy before the patient is permitted to feel free of the likelihood of cancer: Frequency, frequency and nocturnal emissions, frequency and pain, frequency and dribbling, diminution in the size of urinary stream, complete retention, urethral discharge, burning on urination, hematuria, urgency, difficulty in completely emptying the bladder. Barringer (13) contributes a paper based on the study of 280 cases. He says that the symptoms of prostatic cancer are not easily differentiated from those of benign hypertrophy and that, as a matter of fact, carcinoma is often superimposed on a benign hypertrophy. Furthermore, cancer may develop in a prostate of normal size. He found that the initial symptoms were frequency in 47.8 per cent, difficulty in urination in 34.2 per cent, nocturia in 28.2 per cent, dysuria in 21.4 per cent, retention in 16.0 per cent, backache in 9.2 per cent, hematuria in 8.5 per cent, pain in the lower abdomen, hips, thighs and legs, urgency, incontinence, constipation and loss of weight.

He found the most common triad to be frequency, difficulty and nocturia. In eight well advanced cases in this series there were no urinary symptoms. Ferguson (12) found pain to be a major complaint in 60 per cent of his cases. He believes that this symptom is the result of actual invasion of the lymphatics of the nerve sheaths and not to pressure on the surrounding lymphnodes. Among Watson's (18) 194 cases hematuria was the chief symptom in sixteen, or 8.24 per cent. Sixty-five of these patients had had previous prostatectomies.

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DIAGNOSIS: Given a patient who presents one or more of the symptoms above enumerated, the general practitioner should ask himself: Is this the beginning of prostatic cancer? And until he can give an unequivocal negative answer to that question he should not be satisfied with the study of the case. Because the early diagnosis must rest with the general practitioner, prostatic palpation should be a routine step in a physical examination (McCarthy and Kramer, 5). Young (7) points out the fact that prostatic carcinoma generally (but not always) begins as a nodule just beneath the posterior capsule, where it is easily palpable on digital rectal examination. Hypertrophy almost never begins in this region, and the two conditions may have a simultaneous development. If the physician feels that a nodule in the prostate is not malignant, although it may be very hard, the nodule should be excised and examined microscopically if the x-ray study excludes calculus. Crabtree and Brodny (6) find that the x-ray study produces no distinguishing features between prostatic cancer and large, benign hypertrophy and small type of gland, except in those cases in which there is extensive growth with sclerosis of the gland and fixation of the urethra. In such cases the prostatic urethra will be narrowed and irregular, and the normal lobe markings will be lost. In cases in which the growth has extended to the bladder, a cystogram may show bladder distortion.

Muir (14) points out the fact that in the majority of the cases the symptoms are similar to those of benign prostatic enlargement and that it is only on rectal examination that a correct diagnosis can be made. "Practitioners should make rectal examinations more frequently and should be suspicious of every markedly indurated prostate, even if only a small nodule is demonstrable" (Young 7).

Early diagnosis is of the first importance from the view point of the patient's life and from that of the successful treatment by the physician. Barringer (13) found that an average of twenty-four months elapsed between the onset of urinary symptoms and the establishment of the diagnosis in his 280 cases. He recommends a routine examination of the prostate in all men over fifty years of age. Also the physician should be suspicious of carcinoma in every case of difficult urination, frequency, nocturia or retention.

Two authors agree that there are precancerous prostates. Dossot (3) has found that a prostatic adenoma will become malignant in 11.6 per cent of the cases. He

points out that cancer may develop from the glands in the mucous membrane of the urethra as well as from the prostate gland itself. The latter lesion may coexist with adenoma and the two lesions are associated in 58.7 per cent of cases. And McCarthy and Kramer (5) say that the epithelial hyperplasia seen in prostatitis and in prostate hypertrophy may assume the microscopic characteristics of early cancer. Ferguson (12) says that early diagnosis will be facilitated by wider recognition of the fact that the disease may originate in any portion of the organ and that it is not confined in its origin to the posterior lobe. He is an advocate of biopsy for which he recommends the use of a Record syringe and an eighteen gauge needle. His paper describes the technique. Barringer (13) and Gilbert (16) also urge biopsy, and the latter author emphasizes the difficulty in making a differential diagnosis between cancer and prostatic abscess.

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PATHOLOGY: Ferguson (12) suggests an arbitrary clinical index of malignancy based on the age of the patient, the duration of the symptoms, the amount of residual urine, and the extent of the disease. This index is the result of the analysis of 501 of his own cases; 205 confirmed by autopsy and 296 clinically diagnosticated. He found also that by the time the disease was recognized the lymphnodes were involved in the process and the small veins presented thromboses of tumor cells in 36.0 per cent of the cases. In the 205 autopsied cases the perineural lymphnodes were invaded by tumor masses in 52.0 per cent. Cole and Martin (9) report a case of lymphosarcoma of the prostate and have found four other cases in the literature. Dial (15) reports a fatal case of lymphosarcoma of the prostate in a man aged 59 years. Gilbert (16) reports two other fatal cases in boys aged 16 years and 18 years, respectively. Lowsley and Kimball (17) report a case of sarcoma of the prostate in a man, aged 64 years, who died from uremia following ureteral obstruction by an enlarged prostate. The clinical diagnosis was adenomatous hypertrophy; the histological diagnosis was leiomyosarcoma.

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METASTASIS: Dossot (3) points out that prostatic cancer always invades the regional lymphnodes and the organs in relation with the prostate, and usually early. Often before the lesion can be recognized clinically, metastasis has extended beyond the regional lymphnodes and has involved the pelvic and abdominal nodes. O'Crowley, Trubek, and Goldstein (4) refer to the early occurrence of generalized metastases. They say that bone metastasis once begun may extend throughout the skeleton progressively. Further, they point out that in the presence of almost universal marrow involvement, the anemia may not be severe. In the case of sarcoma reported by Cole and Martin (9) the growth had metastasized early to the regional lymphnodes and the adjacent viscera, but not to the skeletal system. Carcinoma, on the other hand, metastasizes to the bones of the pelvic girdle and the vertebral column early. Dickson and Hill (11) report a case of "malignant adenoma" in a man, aged 30 years, associated with metastasis to the bones of the pelvis, the abdominal and thoracic prevertebral lymphnodes, the deep cervical lymphnodes, and the bodies of the seventh cervical and the first thoracic vertebrae. The vertebral metastasis had extended to the vertebral arches and to the ribs, producing angular curvature of the vertebral column with compression and softening of the spinal cord.

In Watson's 194 cases, 111 had carcinomatous infiltration of both seminal vesicles (57.2 per cent), and thirty others had involvement of one vesicle (15.4 per cent).

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TREATMENT: The treatment of cancer of the prostate, like that of all other organs, depends upon early diagnosis and the complete destruction of the growth before metastasis has begun. When a clinical diagnosis can be made there is no method known to give positive evidence of metastasis until the regional lymphnodes are so thoroughly involved that the beginning of distant metastasis is quite likely. Hence the logic of suspicion of prostatic enlargement. Cancer of the prostate can be completely destroyed by irradiation and complete surgical removal is possible only in its early stages. However, there is no cause for complete pessimism if the detection of the growth is somewhat delayed.

Young (7) is an advocate of the radical removal of the prostate, the vesical neck and the seminal vesicles. His paper gives a complete description of the operative procedure which he employs, with good illustrations. He says that urologists should be persuaded to master the anatomy of the perineum and that they should not be frightened at undertaking the radical operation.

Dillon (8) describes the operative procedure which he employs. Muir (14), on the other hand, says that the majority of the patients are unsuitable for radical surgery, although in early cases, if the growth appears to be of low malignancy, some form of radical operation would be justified. His paper is based on the analysis of thirty-two cases. Six were treated with prostatectomy followed by deep Röntgen therapy, three with prostatectomy alone, five with cystotomy followed by deep Röntgen irradiation, five with cystotomy followed by radium, eight with cystotomy alone and five with endoscopic resection. He points out the necessity for the relief of obstructive symptoms. Dean (20) believes that fifteen per cent of the cases of cancer of the prostate can be "controlled" by irradiation. Gilbert (16) is an advocate of treatment with gold radon seed implantations and high voltage Röntgen irradiation by the Coutard technique.

Smith and Peirson (2) have reported the results obtained by high voltage Röntgen irradiation in twenty-five cases. They conclude that the urinary symptoms are not influenced, that pain due to obstruction and cystitis is not affected, but that other types of pain are relieved. In some instances the malignancy of the growth is reduced as indicated by the general condition of the patient. They recommend three or four series of treatments at intervals of two or three months, "but no more."

Muir (14) says: "There is evidence that deep X-ray therapy prolongs life."

Barringer (13) has found the average prostatic carcinoma radioresistant. Nevertheless irradiation is the best form of treatment at the present time. He uses gold radon seeds. The results of radium implantation have consistently improved and he considers them superior to those following resection. He is of the opinion that about ten erythema doses, delivered to the tumor by interstitial applications, are necessary. If the growth is confined to the posterior lobe he uses gold needles inserted into the prostate through the perineum and left in place so that approximately 1000 mc. hours are delivered. Then the needles are removed. If cystoscopy shows marked involvement of the median and lateral lobes, suprapubic implantation of gold seeds should supplement the perineal needles.

Dossot (3) is of the opinion that in the present state of our knowledge treatment should be confined to palliative measures, such as the passage of sounds and cystotomy when cancer of the prostate can be diagnosticated clinically. Prostatectomy and irradiation have given mediocre results.

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PROGNOSIS: In Dossot's cases cures lasting three years were the exception. In Muir's cases the average duration of life was eighteen months. McCarthy and Kramer (5) are of the opinion that a lowering of the incidence of cancer may be anticipated as the result of early investigation and treatment of apparently harmless abnormalities of the prostate.

There is a report of forty-two cases operated upon by Young's technique (7) with four operative deaths (9.5 per cent). The article contains a table which shows nine patients living without recurrence for five years or longer, the longest seventeen years. Four other patients died without recurrence from other pathological conditions after five years. That is thirteen five year cures, or 30.9 per cent. According to the text, however, eleven of twenty-seven patients who left the Brady Institute five

(Concluded on page 54)

Proceedings of the Annual Meeting of the Society of Plastic and Reconstructive Surgery in Abstract

New York Academy of Medicine, October 9, 1934

• Dr. Jacques W. Maliniak, Chairman

Criminal Identification With Relation to Plastic Surgery. Jacques W. Maliniak, M.D.

THE circumstances surrounding the final arrest of Dillinger raise the question of the possibility of hampering criminal identification by means of plastic surgery. It is worthwhile for police officers and physicians to consider to what extent reconstructive surgery can alter the appearance, to learn the tell-tale marks such alterations leave and to attempt to devise measures to prevent the performance of surgery in order to frustrate the law.

Each human being is supplied by nature, several months before birth, with an elaborate identification tag, absolutely individual to himself and impossible to duplicate, which he carries throughout life and even for some time after death. This is the system of epidermic ridges that covers the entire palmar surface of the hands and the soles of the feet. The character of these friction ridges is strongest on the balls of the fingers, where they form a strong pattern of loops, whorls and arches. The design is different, not only for each person but for each digit of the same person; and the evidence of a single finger tip is sufficient to establish an absolute identification.

The finger prints cannot be destroyed by linear scars or by any burns of less than third degree. It is not feasible to replace the skin on the finger tips with grafts from any other part of the body as the skin on the palms and soles has a unique structure and the substitution would be too apparent. Besides, ten separate grafts would have to be performed. It is true that a suspect in a capital case, with fingerprints the principal evidence against him, might subject himself to a third degree burn on each finger tip. Such devices to prevent identification would be avoided by taking the imprint of the whole palm instead of just the last phalanx of each digit.

While the friction ridges are the most absolute method of establishing identity, their evidence cannot be put to practical use unless the suspect is apprehended. Even after the identity of a criminal has been established by fingerprints, the police must usually rely on sight recognition to make the arrest.

The difficulties of sight recognition are many and varied. The same person may look different at various times or there may be strange and baffling resemblances between totally unrelated people. The difficulties of sight recognition are intensified today by the fact that plastic surgery can permanently and painlessly alter most of the features of the face. Fortunately each change is accompanied by some scarring, no matter how cleverly concealed; and in suspicious cases detectives should be trained to look for those scars.

The topography of the forehand can easily be changed by the insertion of a cartilaginous or dermo-fat graft beneath the skin, through an inconspicuous incision above the hairline. The thin scar and a palpable mass beneath the surface indicate that reconstructive surgery has been performed.

Any type of nose can be strikingly changed by the endonasal route. The dimensions of the nose can be changed in all its diameters; the bridge can be raised or flattened; the contour of the nostrils can be altered. When extensive changes are made there are corresponding alterations in the contour of the adjoining parts. However, a thorough search of the mucous membrane by someone experienced in this type of work will reveal a linear scar, flat or thickened. Removal of osteocartilaginous tissue results in callous formation over the bridge which can be felt through the skin. The presence of a bony or cartilaginous graft, or of any implant, is also easily detected.

Hypertrophic lips due to excessive development of the red of the lip may be reduced by the excision of crescent shaped fragments from the mucous membrane. The scar is plainly visible on the inside of the mouth. An underdeveloped jaw can be enlarged by the insertion of a dermo-fat graft and a prognathic chin can be reduced by sawing off crescentic fragments of the jawbone. In either case the scar is concealed in the fold beneath the chin.

The ear, which is one of the most important features of the face from the point of view of identification, can be changed in all its most characteristic points. Its size can be altered symmetrically by excising fragments of skin and cartilage; the lobes can be joined to or detached from the cheeks. Scars must be hunted for very painstakingly as they can be cleverly concealed in the numerous grooves and depressions of the auricle.

"Face-lifting" makes identification more difficult by eradicating characteristic bags, folds and wrinkles and by imparting a fictitious air of youth; but it can hardly be said to conceal identity for it leaves the features untouched. Furthermore, the hairline scar can always be traced.

Scars, birthmarks, tattooing, etc., once prominent features of the Bertillon system of identification, can now be almost completely eradicated, and for the most part without conspicuous scarring. The deformity is excised and the surrounding skin undermined and stretched to cover the defect.

There can be no doubt of the possibility of effectively disguising the appearance by means of plastic surgery and the police should cooperate with reputable plastic surgeons to prevent the use of this specialty for such purposes. In suspicious cases the surgeon should verify the patient's identity and address before operating. A list of legitimate reconstructive surgeons should be on file with both local police and the Department of Justice. When a dangerous criminal is being hunted, particularly if he has a striking facial trait whose obliteration would make sight recognition difficult, the descriptive circular issued by the police could be sent to plastic surgeons to put them on their guard.

The Use of Osteoplastic Flaps in the Repair of Cleft Palate. Warren B. Davis, M.D., Philadelphia, Pa.

A BRIEF historical review considers the pioneers in this type of operation and their contributions to the methods in use today.

The advantages of the operation described are those resulting from a minimum amount of scar tissue and its resulting contractions, and the formation of palates with the greatest possible length and freedom of muscle action permitting gratifying function, in most cases, both as regards speech and deglutition.

A disadvantage encountered by some surgeons has

been the occasional loss of some or all of the bone in the flaps. However, by the routine use of a two-stage operation, attention to minimizing the trauma in the cutting of the flaps, and taking proper precautions to avoid displacing the bone while putting sutures through the flaps, the bone is now very rarely lost. The functional results obtained during twenty-one years of maxillofacial work have made the described procedure the author's favorite method of palate repair.

Zooplasty. H. Lyons Hunt, M.D. New York, N. Y.

A BRIEF outline is given of the history of the transplantation of part or whole organs, including the thyroid, thymus, ovary, testicle, kidney, parathyroid, adrenal, pancreas, pituitary and breast.

My own cases have involved the grafting of skin, fat, nerve, tendon, normal tissue, and among the organs, the thyroid, pituitary, ovary, testicle and pancreas. In the 757 cases in human beings, there were 1 thyroid, 1 pituitary, 327 testicular and 428 ovarian transplantations, performed because of hypofunction or lack of function of the related human organ. Donors used were sheep, rams, young bulls and anthropoid apes.

Successful grafts were obtained in 596 cases. There were 161 cases of non-grafts, in which secondary transplantations were performed. Improvement resulted in 529 cases; 228 cases showed either no improvement or only psychological improvement. Best results were obtained in using young sheep or rams as donors.

Technic will be shown by means of the motion picture.

Renewed vigor, better appetite and sleep, more regular bowel movements, improvement in mental power and memory are usually reported after operation. In men, the libido returns, as well as the power of erection. Blood pressure, blood chemistry and semen return to normal.

Congenital and Acquired Abnormalities Requiring Vaginoplasty. Alfred M. Hellman, M. D. New York, N. Y.

1. The Purpose of Vaginoplasty and its relation to General Plastic Surgery.
   - (a) To remove Abnormalities
   - (b) To repair Defects
   - (a) plus (b) Main object is to restore normal function
2. Congenital Conditions Requiring Vaginoplasty
3. Acquired Conditions Requiring Vaginoplasty
4. Technique of Vaginoplasty
   - Broad principles
   - Need of Individualization
5. Lantern Slides
   - (a) Anatomical Gross Pathology
   - (b) Operations

The Cineplastic Arm. Henry H. Kessler, M.D.

AMONG the large group of the disabled who seek the services of rehabilitation agencies, the case of the amputated arm is one that requires careful consideration. By providing this individual with an artificial arm his employment is facilitated. The prosthesis serves to remove the psychological aversion of the employer toward the cripple, by filling the empty sleeve, and furthermore, the economic prejudice of the employer is also removed by increasing the handicapped person's industrial efficiency through the use of an artificial arm.

Only a small proportion of those supplied with artificial arms wear them, and a still smaller proportion actually use them. The expectations of amputated persons are frequently too great. They hope to be capable of absolutely independent work through the artificial appliance. Although such a goal is impossible to achieve, the nearest approach to this ideal may be obtained through the use of the cineplastic arm. The use of the cineplastic arm in selected cases is of distinct advantage in the rehabilitation of arm amputations. Through the natural control obtained by this procedure, the individual is able to utilize the assistance of the amputated arm in performing the routine pursuits of normal life. With increased efficiency and restored confidence, the disabled person is thus able to effect a perfect social adjustment.

Epiblepharon: Its Surgical Treatment. Isadore Goldstein, M.D.

AMMON[1] in 1841 gave a description of a child that had epicanthus, a slight ptosis with a rolling in of both lower lids forcing the lashes towards the cornea. To the latter anomaly he gave the name of epiblepharon. Similar cases have been reported by Dimmer[2], Bachstez[3], Sziklai[4], Herreuschwand[5], Elschnig[6], Hessberg[7], Bergmeister[8], Yan Chow[9], and Pillat[10]. Most of these cases occur in the new born and in young children. Pillat and Herreuschwand reported cases in the adult. The condition is due to a bulging of the tissues of the lid and in addition a marked hypertrophy of the ciliary portion of the orbicularis, as a result of which the hairs of the lower lid are forced backwards and upwards towards the cornea. Many of these cases correct themselves while others do not. For the correction of the deformity canthoplasty, removal of the ciliary portion of the orbicularis and the Holtz operation have been performed.

Case Report

Female, aged 10 years, whose lashes of both lower lids have been in contact with the cornea since birth without giving rise to any local symptoms. Recently, the rubbing of the hairs upon the cornea has made the patient uncomfortable. The hairs are in contact with the globe in all directions of the gaze, more marked on looking down. On both lower lids is a faint white horizontal line. For the relief of this anomaly the following operation was performed.

Operation. The lower lid is anesthetized with 2% novocain and adrenalin. An incision is made two mm. from the lid margin the entire length of the lid and parallel to it, beginning at the inner canthus and ending about two to three mm. beyond the external canthus. A second incision is made, parallel to the first, starting at the inner canthus and stopping just at the outer canthus. The incisions should be two and a half mm. apart and through skin only. From the upper incision at the outer angle, the skin is incised downwards for a distance of six mm. The lower point of this incision is joined with the outer edge of the lower incision. Having removed the skin between the incisions, the edges are brought together with dermal or silk sutures in the usual manner. By suturing the skin, the entire deformity is not corrected until a mattress suture is passed from within out, at the junction of the middle and outer third of the lid, and then tied through a rubber peg, following which the hairs take the normal direction. The simplicity of the operation commends it.

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The Treatment of Birthmarks. Joseph Jordan Eller, M.D., New York, N. Y.

THE essayist discusses the ideal form of treatment of various birthmarks from the viewpoint of the dermatologist. Plastic surgery is discussed where, by experience, it has been found to be efficacious and preferable in individual cases.

The following birthmarks are to be discussed and will be illustrated by a lantern slide demonstration: pigmented nevi, including hairy nevus and non-hairy nevus; black moles (potential melanomas, melanocarcinomas, melanosarcomas); nevus flamneus, angioma cavernosum; stellary nevus; nevus verrucosus; lymphangioma circumscriptum; fibroma molle and fibroma durum.

The following physical agents have been found to be most useful in the dermatologist's hands in the treatment of birthmarks: radium, carbon dioxide snow; trichloracetic acid and applications; electrolysis (galvanic current): electrodesiccation and electrocoagulation; depending on the size, location, and the type of birthmark, plastic surgery is found to be a necessary procedure.

Commonest Facial Deformities Presenting Themselves For Correction, and Their Correctibility. H. O. Bames, M.D., Los Angeles, California

THE object of this presentation is to bring up for discussion the problems which daily confront us in our practice, rather than those which we meet but seldom.

Granting, because of their very rarity, a greater curiosity interest to the unusual cases, we must at the same time acknowledge that solving well the problems more commonly encountered is of more vital and direct importance, both to us and to the patient.

The patient after having presented his case is entitled to a definite statement as to the result which may be reasonably expected. The plastic surgeon may visualize a certain result, but before committing himself definitely, he must have a clear idea as to the technique and procedure which will bring about the intended result.

Photography, even inexpertly performed, gives the best description of an esthetic deformity, hence the main part of this paper consists in a series of photographs.

Thirty-six slides were projected, simultaneously depicting the original condition and the final result in about fifty different facial malformations. As each slide was shown the technical details of correction were briefly but concisely set forth.

Conceded, that not one of these malformations interfered materially with the patient's physical health, yet each one of them constituted a decided handicap to his mental health, his happiness, his social and economic progress.

Granting, that working far from other centers of plastic surgery one can develop a self-sufficient technique, yet one may also develop notions which bar further progress. Hence the experiences embodied in this review are submitted for discussion, in the hope that notions may be eliminated and perhaps a fairly universally applicable technique evolved for the satisfactory correction of these conditions of daily increasing frequency and importance.

Reconstruction of the Nasal Tip. Claire Leroy Straith, M.D., Detroit, Michigan

THE author calls attention to the increasing importance of nasal reconstruction due to the great number of accidents in the present machine age.

After discussion the various methods heretofore employed in nasal reconstruction and their advantages and disadvantages, the author advances his personal technique for reconstruction of the nasal tip. This consists of the transposition of the upper end of a tube pedicle graft from the area posterior and below the lobe of the ear to the sternal notch.

The advantages of this method are the matching of color and texture, thinner and more easily molded graft, practically hairless, with no forehead scar resulting and the neck scar seldom conspicuous. He also suggests the extension of Kazanjian's technique for supporting the nasal tip by everting the lateral wings of the alar cartilage and forming cartilage flaps, stitching them back to back to raise the nasal tip.

Cancer

(Concluded from page 51)

or more years ago were living without recurrence, or 40.0 per cent.

In Dillon's (8) report of thirty-one cases, one patient was living without recurrence six years after operation.

Barringer (19) claims ten to fifteen per cent five year cures after treatment with radon. Dean (20) agrees with this percentage.

●

SUMMARY: The physician who is consulted by a patient for urinary symptoms should be suspected of having cancer of the bladder, the kidneys, the prostate, or some other portion of the urinary tract. It is the physician's duty to exclude cancer of the genitourinary tract before proceeding along some other line. If the patient complains of sciatic pain, cancer of some pelvic organ should be suspected. In any event a digital rectal examination should be made. Prostatic abnormalities discovered on rectal examination should be looked upon as potentially malignant. In doubtful cases biopsy should be done. It should be done, however, with great care, preferably by an operator with considerable training and experience.

Once the diagnosis is made the treatment ought to be decided upon only after consultation with the urologist and the radiologist. The treatment of cancer is not a one man job; it should be conducted by a team. It is folly to undertake elaborate surgical procedures in cases in which skeletal and other distant metastases have already taken place.

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Dinitrophenol in Obesity

There seems to be agreement at present that dinitrophenol is a drug of potential dangers when used indiscriminately. Its sale should be restricted to that ordered by the physician's prescription and its use by medical men should be carefully supervised. Probably it should be employed only when reduction of obesity is important and when ordinary dietary methods have failed.—*Jour. A. M. A.*, Dec. 22, 1934.

Highly Deficient

Patient: "I understand fish is good for the brain. Can you recommend anything special?"

Contemporary Progress

Rhinolaryngology

Histology of the Epithelium of the Paranasal Sinuses

J. S. Latta and R. F. Schall (*Annals of Otology, Rhinology and Laryngology,* 43:945-971, December, 1934) report a study of the histology of the sinus epithelium in specimens obtained at operation from patients with nasal sinus disease; specimens obtained at autopsy from persons without evidence of upper respiratory tract or sinus infection; and specimens from animals of various species. Normally they found that the simplest type of epithelium lining the paranasal sinuses was a simple columnar ciliated epithelium with only occasional basal cells. In the human sinuses and in those of the domestic animals the epithelium was more commonly pseudostratified with a larger number of undifferentiated basal cells and either columnar or cuboidal epithelial cells; in this type of epithelium practically all the superficial cells had long and numerous cilia. There were no or very few goblet cells. This type of epithelium was most commonly found in the maxillary and sphenoid sinuses, and was associated with a relatively thin underlying connective tissue stroma. When there was an acute irritation, the basal cells grew and differentiated more rapidly, and brought about a hyperplasia of the epithelium, which became thicker with the cells "more closely packed"; the superficial cells were also more heavily ciliated. Sometimes this process may continue until a true stratified columnar epithelium results. With this type of epithelium the underlying connective tissue is infiltrated with macrophages, polymorphonuclear leucocytes and lymphocytes. In other types of epithelia hyperplasia, large numbers of goblet cells were found, greatly compressing the ciliated cells, which sometimes almost entirely disappeared. While the goblet cells usually arose from the basal cells, it appeared that occasionally the ciliated cells became transformed into goblet cells. The presence of these mucin-secreting goblet cells in large numbers indicates a degenerative process. The underlying connective tissue is very dense, sometimes nearly hyaline. The undifferentiated basal cells are not usually involved in any degenerative process and appear to be capable of regenerating the epithelium by the formation of either ciliated or goblet cells, "depending upon the environmental stimulus present while they are differentiating."

COMMENT

Numerous researches have been made on this subject within the past decade and, although they are very interesting from the viewpoint of research, none of them has added much to our knowledge of the fact that there is a definite ciliated epithelium which provides a certain protection to the respiratory mechanism. The authors indicate that sometimes the ciliated cells become transformed into goblet cells which indicate a degenerative process of the mucous membrane.

H. H.

Sinusitis in Pneumonia

E. H. Campbell (*Archives of Otolaryngology,* 20:696-703, November, 1934) reports that in 130 patients with lobar and bronchopneumonia — mostly children — acute sinusitis was present in all. Only 7 adults were included in this series, as the author has only very recently begun to study the condition of the sinuses in pneumonia in adult patients. The ages of the other patients varied from three weeks to fifteen years. In all but 5 cases pus was observed coming from the sinuses. The diagnosis of sinusitis was made in all but 10 cases by examination with the nasopharyngoscope; in these 10 cases the diagnosis was made from the roentgenograms. In 59 of the patients examined with the nasopharyngoscope, pus was found in the middle meatuses and spheno-ethmoid recesses of both sides; in 31 patients in both recesses only; in 7 patients in the middle meatus and spheno-ethmoid recess of one side only; in 6 patients in one spheno-ethmoid recess; in 10 patients in both middle meatuses only; and in 2 patients in one middle meatus only. In the 15 patients who were examined roentgenologically, 9 showed increased density in both antrums and ethmoids, one density in the left antrum and ethmoid, and one in both ethmoids; in the other patients—young children—the roentgen findings were indefinite, but the diagnosis of sinusitis was established by examination by the nasopharyngoscope. The author is of the opinion that sinus infection is a possible etiologic factor in the production of pneumonia, and that early efficient removal of the pus from infected sinuses might lessen the incidence of pneumonia, especially in infants and young children.

COMMENT

The majority of the patients in this series are children varying in age from three weeks to fifteen years. The majority of patients showed pus coming from one or more of the sinuses, mainly from the middle meatus in the ethmoid region. These observations are definitely interesting but are not unusual. It is rather bromidic to say that the majority of pneumonias in children come on after the child shows evidence of an infection in the nose. We agree that it would be wise to treat such an infection before a pneumonia develops, but what is of more importance, is the outline of a routine procedure whereby children are taught preventive measures so that they will not get infections of the upper respiratory tract.

H. H.

Sinusitis and Asthma

C. E. Connor (*Minnesota Medicine,* 17:582-587, October, 1934) notes that suppurative lesions in the nose and accessory sinuses in cases of asthma should be treated on the same indications as similar lesions in non-asthmatic patients. There is considerable difference of opinion on the relation of non-suppurative (hyperplastic) lesions of the sinuses to asthma. Whether such lesions represent an allergic reaction, or chronic infection, or infection plus allergy constituting also a chronic focus of infection is a problem which must be decided by careful study by the

rhinologist. A rhinological study of a case of asthma should include: The usual inspection and transillumination of the sinuses, cultures from the spheno-ethmoidal area and nasopharynx, and skin sensitization tests made with the organisms found. Differential cell counts on nasal smears should be done to determine the percentage of eosinophiles and neutrophiles; a high percentage of eosinophiles indicates an allergic condition rather than an infection. X-ray examination should be made with instillation of an opaque medium. A single antrum puncture should be made and antroscopy done; the antrum is washed out with sterile salt solution, and half of the material used for culture and half for cell count. These studies aid in the evaluation of the relative importance of allergy and infection in the causation of the asthma in each case. In the author's experience, treatment of non-suppurative foci of infection in the nose and the sinuses in cases of asthma relieves certain local symptoms—obstruction, discharge and a tendency to acute head infections—but does not cure the asthma. The only case in which such treatment would be curative would be if the nasal infection constituted a focus causing the asthma by the production of bacterial allergy.

COMMENT

The statement of most importance in this paper is that treatment of non-suppurative foci of infection in the nose and sinuses in cases of asthma relieves certain local symptoms—obstruction, discharge and the tendency to acute head infections—but does not relieve the asthma. It has been our experience that there are so many other factors concerned in asthmatic cases that nasal treatment is of little avail even when the most severe operative procedures have been performed. Regardless of the fact that one should make most careful nasal examinations, one should assure the patient that seldom does nasal instrumentation do any good. For years packing of the nose with argyrol and other types of medication was advocated. Many times complete radical operations on the sinuses have been performed but the result has been complete failure in ninety cases out of one hundred. We had hoped that ionization of the nasal mucosa, as suggested by Warwick, would be of some help, but even this treatment has resulted in failure.

H. H.

Roentgenological Study of Tuberculosis of The Larynx

H. K. Taylor and L. Nathanson (*American Journal of Roentgenology*, 32:589-607, November, 1934) have found that lateral roentgenograms are of aid in the diagnosis of tuberculosis of the larynx; at least two roentgenograms should be made, one with the larynx at rest and one during phonation. They report 100 cases of laryngeal tuberculosis examined roentgenologically and classify the lesions observed in three groups. There were 15 cases with minimal lesions, *i.e.*, a small localized swelling in the ventricle or a small circular or oval shadow encroaching on the ventricular air space. There were 56 cases with moderate lesions involving chiefly the arytenoid eminences and extending either above or below them; an upward extension causes thickening of the aryepiglottic folds, a downward extension, changes in the ventricular space. There were 29 with extensive lesions, with massive involvement of the laryngeal structures. Three of the patients with minimal lesions, 4 of those with moderate lesions, and one with extensive lesions clinically showed no laryngeal symptoms. The predominating symptom in the other cases was hoarseness. With the lateral roentgenogram the height and width of the lesion, as well as any subglottic extension is demonstrated; small ventricular lesions, which may be missed on laryngoscopic examination, are demonstrated. Roentgen examination also gives a "permanent pictorial record" of the location and extent of the lesion; and is thus a valuable supplement to the laryngoscopic examination.

COMMENT

It is extremely interesting to review the observations recorded in this paper because it is of decided interest to know that x-ray pictures of the larynx, one taken during rest and one during phonation, will reveal lesions which can be shown definitely to be tuberculosis. The authors do not state how far these lesions had advanced except to say that fifteen cases showed very small lesions. However, we are of the opinion that intrinsic laryngeal tuberculosis is a rarity and that it is almost always secondary to a lesion in the lungs which has already been diagnosed.

H. H.

Surgical Relief of Painful Deglutition in Laryngeal Tuberculosis

L. Savitt and S. H. Soboroff of the Chicago Municipal Tuberculosis Sanitarium (*Illinois Medical Journal*, 66:444-447, November, 1934) describe their technique for section of the superior laryngeal nerve, which is the sensory nerve of the larynx. They have used this method in 7 cases of advanced laryngeal tuberculosis for the relief of painful deglutition. They have found the operation "absolutely safe," and have observed no undesirable complications. In all cases the pain of swallowing was definitely relieved, and the patient's general condition improved because of the relief of pain, increased rest and ability to take more nourishment. The authors advocate the early use of this operation in cases of laryngeal tuberculosis where pain is severe and interferes with rest and proper nutrition.

COMMENT

The severe pain on swallowing in laryngeal tuberculosis may be so great that a person regurgitates all his food, sometimes through the nose. This paper is an extremely valuable addition to our knowledge of surgical procedures in such cases and the suggestion given of a simple procedure may mean the elimination of one of the severest symptoms of this disease.

H. H.

Frequency of Lupus Vulgaris of the Upper Respiratory Tract

C. Ebskov (*Folia oto-laryngologica*, Pt. 1, 25:281-287, November, 1934) reports that at the Finsen Institute of Copenhagen, 823 cases of lupus vulgaris were seen in ten years to January, 1933. There were 742 with lupus of the skin, in 280 of which the mucous membrane of the upper respiratory tract was also involved; and in addition 81 cases of lupus of the upper respiratory tract with no cutaneous involvement. The nasal cavity was involved in 92.3 per cent. of the cases with lupus of the mucous membrane, and in 61.7 per cent. it was the only site involved. The larynx was involved in 37 cases, but a primary lesion involving the larynx alone was found in only 3 cases. Primary lupus of the larynx is undoubtedly a rare condition. An examination of the lungs was made to determine the frequency of a complicating pulmonary tuberculosis in these cases. In the cases of lupus involving both the skin and the respiratory tract mucosa, pulmonary tuberculosis was found in 19.2 per cent.; in cases involving the respiratory tract mucosa alone in 11.8 per cent.; and in the cases in which the larynx was involved in 21.6 per cent. In most of these cases the pulmonary tuberculosis was of an inactive fibrous type.

COMMENT

We agree with the author that primary lupus of any part of the upper respiratory tract is extremely rare. The percentage of involvement of the mucosa in cases associated with lupus of the skin is greater than one would expect.

H. H.

Otology

Auditory Fatigue

E. M. Josephson (*Annals of Otology, Rhinology and Laryngology*, 43:1103-1113, December, 1934) reports a study of auditory fatigue as measured by variations in the threshold of intensity. It was found that prolonged stimulation with submaximal intensities designed to produce

auditory fatigue did not do so in normal subjects, but on the contrary caused an increased acuity of hearing as shown by a lowered threshold. In ears in which the "accommodative mechanism" of the middle ear was defective, however, fatigue was manifested by a rise in the threshold of intensity. This may be considered as the earliest sign of progressive deafness. To this middle ear "mechanism" must be attributed in part the increased acuity of hearing acquired by the trained ear. As a result of his study the author suggests a new theory of the mechanism of hearing, which he believes explains the phenomena observed more satisfactorily than the accepted "mechanical theories." This theory predicates that the mechanical energy of sound is converted into electrical energy by the cochlea; and that the organ of Corti is stimulated by the "audio-frequencies" thus produced.

COMMENT

In numerous papers in the past we have spoken of auditory fatigue and consider it one of the most vital factors in the actual determination of the patient's deafness. We are glad that the author has again brought this subject to our attention. We are also happy to note that he has questioned the mechanical theories of deafness and suggests an electrical one. In a book which we published a few years ago, "The Modern Conception of Deafness," we brought out a new theory of hearing, based upon the amplification of sounds in the cochlea or auditory nerve, and feel sure that the time will come when such a theory will be accepted.

H. H.

Children with Impaired Hearing

A. W. Rowe (*New England Journal of Medicine*, 211: 954-961, Nov. 22, 1934) reports a thorough study of 44 children with definite impairment of hearing; 23 were boys and 21 were girls. While the loss of hearing was demonstrable by hearing tests, only 22 had noted deafness, "past or present"; 11 reported discharging ears, and 12 complained of tinnitus. Everyone of this group of children showed some departure from physical normality. In 17 cases there was some definite injury to the central nervous system from trauma or disease; and in 14 some endocrine disorder involving the pituitary or the thyroid chiefly. In 25 of the group the hearing loss was bilateral, and in 19 it was unilateral; in 6 cases the loss of hearing was classed as slight, in the remainder as moderate or severe. Of the 25 cases with bilateral impairment of hearing, the two ears showed an equal degree of impairment in 13 cases, and in 12 cases one ear was more seriously affected than the other.

COMMENT

The question of impaired hearing in children is receiving universal attention in the United States. It has frequently been stated that over three million children attending the public schools of this country have an impairment of hearing which retards their progress. Recently Fowler of New York presented some statistics on over three hundred thousand school children in New York City which demonstrated the fact that well over five per cent needed medical attention and particularly attention to the ear mechanism. The hearing of such children can be conserved if taken care of at this early age.

H. H.

Bacteriology of the Acute Infections of the Middle Ear and Mastoid

J. R. Page (*Archives of Otolaryngology*, 20:447-451, October, 1934) reports a study of the bacteriology of 300 acute infections of the middle ear, in all of which myringotomy was indicated; in 231 cases the ear drum was not perforated at the time of the myringotomy; in 69 cases the ear was discharging; the average duration of the infection was eight days in the latter group, and five days in the cases without discharging ears. In the 300 cases, the infection was found to be due to the hemolytic streptococcus in 92 cases, or 30.6 per cent.; and to the pneumococcus type III in 51 cases, or 17 per cent. One hundred and seventy-one patients were followed to recovery; of these 18 were operated on for mastoiditis; in this group the hemolytic streptococcus was the infecting organism in 51 cases and 9 or 17.6 per cent. of these patients required operation for mastoiditis; pneumococcus type III was the infecting organism in 35 cases, and 7, or 17.1 per cent. of these patients, required a mastoid operation. None of the patients operated for mastoiditis developed complications. No case of meningitis occurred in the 171 cases that were followed to recovery, nor, as far as is known, in any of the 300 cases. In this series the pneumococcus type III was not as "universally destructive" as others have found it to be, yet the presence of this organism always warrants a guarded prognosis because of its insidious and virulent character. In this series operation on the mastoid was three times more frequent in those cases in which the drum ruptured spontaneously than in those in which myringotomy was done before rupture occurred, showing the advisability of early myringotomy in acute ear infections.

COMMENT

That the Streptococcus hemolyticus and the pneumococcus type III are the bacteria which cause the most acute infections of the middle ear and mastoid is not to be questioned. The chief thing that interests us is that the virulence of bacteria seems to change over the course of years. For example, in 1921 there was a definite epidemic of middle ear infections, with mastoiditis and severe complications. The types of bacteria causing the infections were the same as those reported by this author, but the pneumococcus type III was then called the Streptococcus mucosus. Since that time ear infections and mastoid infections have been milder in character, so that the proportion of recoveries is greater.

H. H.

Aural Tuberculosis

J. Miller (*Archives of Otolaryngology*, 20:677-692, November, 1934) reports a study of 102 cases of chronic purulent otitis media in adults with chronic pulmonary tuberculosis. In 69 cases there was no laboratory evidence that the otitis media was tuberculous in nature; and in 33 cases there was definite evidence of a tuberculous ear infection. The aural tuberculosis in these cases was of a benign nature without appreciable involvement of the temporal bone and without fatal complications. The presence of the ear infection did not appear to influence the underlying tuberculous condition unfavorably or to hasten a fatal outcome. The average age of the patients with tuberculous otitis media was less than that of the patients with non-tuberculous otitis. All of the patients with tuberculous otitis showed positive sputum; and the infection of the middle ear appears to result from active pulmonary lesions by way of the nasopharynx in these chronic cases. In acute cases the infection is evidently hematogenous. Tuberculous otitis in these chronic cases usually produced an extreme degree of deafness with a chronic ear discharge, but was painless. An otitis of this type in a young adult with chronic pulmonary tuberculosis, the author concludes, may usually be regarded as tuberculous; but definite evidence of its tuberculous nature can be obtained only in the laboratory by the demonstration of the tubercle bacilli in the discharge.

COMMENT

It is interesting to note that tuberculosis of the middle ear is almost always secondary to a tuberculosis of the lungs. This stands in line with the teaching that tuberculosis of any part of the upper respiratory tract is almost always secondary to tuberculosis of the lungs. We have seen one or two instances of primary tuberculosis of the middle ear which could be positively diagnosed by the inspection of multiple perforations of the drum and a discharge which, on examination, showed tubercle bacilli.

H. H.

Roentgen Therapy in Acute Mastoiditis

W. P. Cherniak and A. A. Gorodetzky of Leningrad, U. S. S. R. (*Journal of Laryngology and Otology*, 49:675-678, October, 1934) report the treatment of acute mastoid-

itis with the Roentgen-rays. The mastoid process is fully exposed to the X-rays, using an area of 3 x 4 sq. cm. for large mastoids and of 2 x 3 sq. cm. for small mastoids; with 110 kilovolts and a 2 mm. aluminum filter, the dose is ⅛ an erythema dose. Further treatments are given as indicated with an interval of four to five days between the first and second treatment and fourteen days between subsequent treatments. Up to the end of 1931, 44 cases of acute mastoiditis were treated by this method with 50 per cent. recoveries without operation. Since 1932, 62 cases of acute mastoiditis have been treated with the X-rays; of these 46 were entirely cured; 14 were lost track of, but were considerably improved after three or four treatments; only 2 patients had to be operated. In 12 cases the mastoiditis was a complication of a severe infection and the patients were very weak with greatly diminished resistance rendering them poor surgical risks. X-ray treatment proved of great value in these cases, relieving pain and improving the general condition of the patient; only one of these cases required operation in addition to the X-ray treatment. In none of the cases treated with the X-rays did any complications develop.

M. S. Ersner and L. H. Weiner of Philadelphia, (*Medical Record*, 140:588-591, Dec. 5, 1934) report the use of the X-rays in the treatment of persistent suppuration of the middle ear after radical mastoidectomy. They have found that this results in cessation of suppuration when all other methods fail. An average of eight treatments were required in their cases. Roentgen therapy, they state, acts in these cases by destroying the granulation tissue and thus permitting epidermization of the middle ear.

COMMENT

We are rather critical of this paper and entirely disagree with this type of treatment. Although the authors claim that the majority of cases were cured without operation, we feel that such patients would have been cured by Nature in any event. To watch a case of mastoiditis over a period of weeks and months means that frequently a definite extension of the infection has taken place until some vital part is affected. Regardless of the fact that x-ray therapy is not justified in acute middle ear and mastoid infection, it may prove of considerable value in chronic suppuration of the middle ear after a radical mastoid operation has been performed. In such cases we are dealing with an entirely different situation in which rational observation over a long period of time is more than justifiable.

H. H.

Injury to the Internal Ear in Food Poisoning

Zavliska (*Monatsschrift für Ohrenheilkunde*, 68:1333-1338, November, 1934) notes that the eighth nerve may be injured by various types of toxins. In cases of food poisoning both the cochlear and the vestibular portion of the nerve may be affected—the latter most frequently. He reports 8 cases of food poisoning in which symptoms of vestibular lesions persisted after the acute symptoms of poisoning had subsided. Vertigo and nystagmus were the chief symptoms and the tests showed definite evidence of injury to the vestibular nerve. In 5 of these cases the cochlear branch was also involved, with tinnitus and some loss of hearing, but in none of these cases did a permanent deafness develop. In these cases, the author found that non-specific protein therapy was effective and resulted in prompt relief of the symptoms.

COMMENT

In the past we have frequently stated that a temporary or permanent infection of the internal ear or the auditory nerve itself may result from a gastro-intestinal intoxication, which basically means that we are dealing with a food poisoning. We agree with the authors that such food poisoning seldom results in a permanent impairment of hearing or a permanent vertigo or nystagmus. Any toxic poisoning may give rise to the most severe pains, simulating sinus disease, or may result in an irritation of the auditory apparatus. Nonspecific protein therapy is not necessary. A good dose of calomel, followed by salts, and daily high colonic irrigations will prove just as effectual.

H. H.

Gynecology

Endometrial Findings in Functional Menstrual Disorders

B. M. Anspach and J. Hoffman (*American Journal of Obstetrics and Gynecology*, 28:473-481, October, 1934) report that they have studied the endometrium in cases of amenorrhea and of uterine bleeding. The cases studied included 96 cases of amenorrhea, 97 cases of uterine bleeding and 42 cases of apparently normal menstruation, under treatment for dysmenorrhea, sterility and obesity. The specimens of mucosa were obtained by curettage a day or two before the expected onset of menstruation; in some cases this was not easy to estimate, and when there was no way of determining it, the curettage was done irrespective of the flow. In both the groups of amenorrhea and of uterine bleeding all types of endometria were found. In the amenorrhea group, the atrophic and premenstrual types predominated; the percentage of the atrophic type increased and the percentage of the premenstrual type decreased with the duration of the amenorrhea; in amenorrhea lasting over one year, the atrophic type was nearly twice as frequent as the premenstrual type. In the cases with uterine bleeding the hyperplastic type of endometrium predominated, being found in more than one-half the cases; the premenstrual type was found in about one-third. Considering the two groups of cases together, the premenstrual and interval types of endometrium were found in almost equal proportions in the two groups; there were two and a half times more cases of uterine bleeding than of amenorrhea associated with a hyperplastic endometrium; and three times as many cases of amenorrhea as of bleeding associated with an aplastic endometrium. In the group with normal menstrual cycle, all types of endometria were found, but the premenstrual type predominated, being present in over three-fourths of the cases. These findings lead the authors to conclude that amenorrhea, abnormal uterine bleeding and normal menstruation may be associated with many different states of the ovary; and that uterine bleeding may be due "to some positive mechanism thus far unexplained."

COMMENT

It is only by such clino-pathological studies as these that the problem of menstruation can finally be solved. There was a time when we thought we knew all about the physiology of menstruation, but as "time and science march along together" we are about to acknowledge that we know comparatively very little. These very competent men working with sufficient material under satisfactory conditions found nothing new, but negative information is of some value and perhaps may lead to positive findings by the next investigator. It's all worth while.

H. B. M.

Malignant Disease of the Female Generative Organs in the First Three Decades of Life

B. F. Schreiner and W. H. Wehr (*Surgery, Gynecology and Obstetrics*, 59:616-621, October, 1934) report that of 2,405 patients with malignant disease of the female generative organs treated at the New York State Institute for the Study of Malignant Disease, 114 or 4.6 per cent. were thirty years of age or younger. The authors note that they "were somewhat astonished to find" so large a percentage of gynecological malignancies in young women. Eighty of these 114 cases in young women were malignant growths of the cervix, representing 4.9 per cent. of all cervical cancer; 23 were malignant growths of the ovary, representing 10.6 per cent. of all ovarian malignant tumors. Cure was obtained in cervical cancers of groups I and II in about the same percentage as the general average for cancer of the cervix of these groups—50 and 33 per cent. respectively. Treatment in the more advanced cases of cervical cancer was only palliative; no five year cures are recorded in these cases in this group of young women. There was one case of epithelioma of the vagina in a woman thirty years of age and four months pregnant. Treatment with radium resulted in prompt regression of the tumor; the birth of a normal healthy child; and no recurrence in fourteen months. The authors have pre-

sented this paper "for the sole purpose of calling attention to the frequency of malignant disease of the female generative organs at the early age of thirty years or less." In order to discover and treat early lesions of the cervix, they urge that careful gynecological examination should be made bimanually and with a speculum, with biopsy and cauterization in cases with so-called cervicitis and erosion in order to rule out or discover early malignancy.

COMMENT

We have always taught that "a patient may have cancer at any time from the time she is born until she dies" but that the most frequent age period is between 40 and 60 years. This study confirms the statement. 4.6% of 2405 female patients, 30 years of age or less, with cancer of the generative organs, is something every physician should keep in mind. Early diagnosis is the only hope of cure, hence do not think simply because your patient's age is under 30 (or even 20) that she may not have cancer. Indeed! she may; and if you do not make the diagnosis *early, when the cancer is a local affair, you have not done your duty toward such a patient.*

H. B. M.

Present-Day Trend in the Treatment of Uterine Fibroids

J. L. Baer, R. A. Reis and E. J. De Costa (*American Journal of Obstetrics and Gynecology*, 28:842-856, December, 1934) present an analysis of 1,001 cases of fibroids of the uterus treated at the Michael Reese Hospital, Chicago, in the past eleven years. Various types of ovarian pathology were found in association with the fibroids in these cases, chiefly follicle cysts (in 244 cases) and luteum cysts (in 129 cases). One or both ovaries were removed in 432 cases, or 46.7 per cent., of the patients operated, not always because of definite pathological conditions in the ovary, but in some cases to facilitate removal of the fibroids or because of impairment of circulation. Of the 1001 patients in this series, 73.5 per cent. had had children, and an additional 6.9 per cent. had been pregnant and aborted, so that there was absolute sterility in only 19.6 per cent. Such sterility was not apparently due to either the presence of the fibroids or pathological conditions in the ovary, but to pathological conditions in the tubes. In this series there was a steady increase in the percentage of cases operated as compared with radium treatment from 1923 to 1933. The frequency of total hysterectomy increased from 1.4 per cent. in 1923 to 14.6 per cent. in 1933; vaginal hysterectomy from 5.5 per cent. to 18.1 per cent. Supravaginal hysterectomy is the method most frequently used for the treatment of fibroids;-it was employed in 57.6 per cent. of all cases in 1933. It is usually the simplest and most rapid operation; rarely involves risk to the ureters or bladder; and "insures complete removal not only of the existing tumors but of the potential tumor-bearing tissue." The mortality is exceedingly low. No instances of carcinoma of the cervical stump have been observed. The use of radium for the treatment of fibroids has steadily decreased; it was used in 15 per cent. of cases in 1923, and in only 2.1 per cent. in 1933. There are a considerable number of direct contraindications to the use of radium; it causes a "precipitate menopause"; and radium treatment does not permit an examination of the pelvic and abdominal viscera. The total mortality for the series was 0.7 per cent. (7 deaths); in the last group of 484 cases, there was only one death, a mortality of 0.21 per cent.

COMMENT

This study reveals the common trend in the treatment of fibroid tumors of the uterus—i.e., a decrease in the number irradiated and an increase in the number operated. Given a patient in good general condition, operation by supravaginal hysterectomy for those tumors larger than a three months pregnancy gives better results than irradiation. Pedunculated or submucous fibroids should always be operated upon in preference to irradiation. Smaller intramural tumors are perhaps best irradiated since there should be no primary mortality and the final results are quite satisfactory. Where there exist contraindications to operations irradiation is indicated regardless of the size or type of tumor.

We should never say "operation vs. irradiation" but always "operation or irradiation" in the treatment of uterine fibroids. Either method is perfectly satisfactory in properly selected cases.

H. B. M.

Chronic Cervicitis

J. C. Ainsworth-Davis (*British Medical Journal*, 2:935-937, Nov. 24, 1934) states that in his practice as a urologist, he has become convinced that many urinary troubles in women are due to inflammation of the urinary tract resulting from a spread of infection from a chronic cervicitis. In the usual case the symptoms are urinary frequency, dysuria, and back pain. Examination shows a trigonitis and urethritis, and often some urinary obstruction and dilatation of the renal pelvis due to inflammatory adhesions between the ureter and the pelvis. These women show chronic cervicitis or cervical erosion, with or without some laceration; and often tenderness and thickening of the fornices. Animal experiments have shown the possibility of a perivascular lymphatic spread of infection from the region of the uterine cervix to the trigone of the bladder and upward to the kidney. If treatment in the cases of the type described is limited to the urinary tract alone, the results are not satisfactory. It is necessary to treat the cervical lesion in order to relieve the urinary symptoms. The author has found that the best method for the treatment of cervicitis is the removal of the lining membrane of the cervix (and if necessary of the pars intermedia) and the subjacent glands by the diathermy cutting current. For this purpose he has designed a series of cutting current curettes of various sizes; these curettes are loops of fine tungsten wire, elliptical in shape, and attached at an angle of 30° to an insulated metal rod. The loops are so constructed that strips of lining membrane and underlying glands are removed in one piece. The author has found the results of this treatment to be excellent in chronic cervicitis, especially if it has given rise to bladder or renal symptoms. Vaginal discharge, urinary frequency, dysuria, renal pain, and backache disappear; and no distortion or contraction of the cervical canal has been observed in any of the cases operated.

COMMENT

It has been stated that from 60 to 75% of all women have some degree of chronic endocervicitis and about 20% of these have some degree of urinary infection. It would appear, therefore, that chronic endocervicitis, particularly if of gonorrheal origin, might very well be an etiological factor in the causation of inflammatory lesions along the genito-urinary tract. Eradication of the cervical infection plus proper treatment of the urinary infection does prove successful in the majority of cases. Consequently, every gynecologist should be in position to diagnose and treat the ordinary urinary infections. Likewise every urologist should be able to recognize the rôle that pelvic infections play in the causation of lesions in the urinary tract.

H. B. M.

Endometriosis as a Manifestation of Ovarian Dysfunction

T. N. A. Jeffcoate and A. L. Potter (*Journal of Obstetrics and Gynecology of the British Empire*, 41:684-707, October, 1934) report a study of 113 specimens from 111 cases of endometriosis. Of the 111 cases, 33 showed lesions of the uterine wall alone, and 78 extra-uterine endometriomata with or without an associated myometrial lesion; in 62 of these cases the ovary was involved and in 45 cases the recto-vaginal septum or peritoneum of the pouch of Douglas. Of the married women in this series, 45 per cent. were sterile; 79 (or 72 per cent.) had excessive menstrual bleeding or irregular blood loss. In 73 cases in which the ovaries were examined, 33 showed follicular cysts. The uterine mucosa in these cases in which it was examined showed hyperplasia, or other features dependent on excessive estrin stimulation. The endometrioma showed, as a rule, hyperplasia, especially of the glandular elements, and sometimes gross edema of the stroma. From these findings the authors conclude that

whatever the primary source of the endometrial tissue in endometriomatosis, the development of the endometrioma is due to an excessive production of estrin by the ovaries. In most cases of endometriomatosis definite evidence of follicular overactivity is found. This theory appears to explain the known clinical and pathological features of the disease more adequately than any other.

COMMENT

The subject of endometriosis has caused much discussion amongst gynecologists since Sampson revived the subject some 10 years ago. This report bears out the well known fact that whatever the primary source of the endometrial tissue in endometriosis the development of the endometrioma is due to an excessive production of estrin by the ovaries. Excision of the endometrioma is the proper treatment. Irradiation is contraindicated.

H. B. M.

The Conservation of the Uterus After Bilateral Salpingo-Ovarectomy

H. Constantini (*Presse médicale*, 42:1878-1880, Nov. 21, 1934) maintains that the uterus should be left *in situ*, provided that it is normal, when the tubes and ovaries on both sides are removed. In some instances—from 30 to 40 per cent. according to various statistics—the woman may continue to menstruate if the uterus is preserved. Why this is so is difficult to determine; it may be that some fragments of ovarian tissue remain that continue to function. If an early ovarian graft is made, menstruation may continue in 70 per cent. of women after bilateral ovariectomy, and all postoperative menopausal symptoms be avoided. Whether menstruation persists or not, the author has found that the postoperative symptoms are less severe when the uterus is not removed. The author has recently operated 38 cases in which both tubes and ovaries were removed, but the uterus conserved; there was one death in this series due to hemorrhage and infection; 40 per cent. of the patients continue to menstruate. The author maintains that there is a definite physiological and psychological value in the continuation of menstruation; not only are menopausal symptoms avoided, but the patient feels that she still "preserves her femininity."

COMMENT

There is no question that the preservation of the uterus after bilateral salpingo-ovariotomy is always indicated in women 35 or younger, provided enough ovarian tissue is retained to permit menstruation. When this is not possible we do not agree that the uterus should be retained. In fact, we know from considerable experience that the majority of these infected cases do better, after the menopause is established, when complete hysterectomy with double salpingo-ovariectomy is performed. Transplantation of an ovary or parts of this organ have not given the good results once claimed for this procedure, although in selected cases we have obtained fairly satisfactory results.

H. B. M.

Obstetrics

Analysis of Errors in Pregnancy Tests

L. Davy and E. L. Sevringhaus (*American Journal of Obstetrics and Gynecology*, 28:888-901, December, 1934) present an analysis of 425 cases tested for pregnancy by methods based on the Aschheim-Zondek reaction. Three methods were used—the Schneider immature rabbit test, the Friedman rabbit test and an immature female rat test; in some cases only one test was employed, in some two or three tests. Correct diagnoses were made in the entire series in 90.59 per cent. In 229 cases of pregnancy, the test was correctly positive in 94.76 per cent., and falsely negative in 5.24 per cent.; in 196 non-pregnant cases, it was correctly negative in 85.20 per cent., and there were 14.80 per cent. false positives. In 2 of the pregnant cases giving a false negative, the pregnancy was in a very early stage when the first test was made, but a positive test was obtained later. In 9 pregnancies of more than one month duration giving a false negative, there was a definite pathological condition (fetal or maternal) in 7 cases; and in one the history was unreliable. It was found that in the earlier pregnancies more consistently accurate results were obtained by a modification of the Friedman rabbit test or by the immature female rat test than by the Schneider immature rabbit method. In the non-pregnant cases, it was found that most of the false positives were obtained in cases with demonstrable endocrine disturbances. In cases of ovarian dysfunction, the concurrent application of two or more tests is necessary to differentiate between pregnancy and non-pregnancy; the Schneider immature rabbit test and the immature female rat test are most accurate in cases of this type; the Friedman rabbit test is more sensitive and is of value in demonstrating gonad stimulating substances in the urine of non-pregnant individuals.

COMMENT

The Aschheim-Zondek reaction of pregnancy establishes a distinct "landmark" in obstetrics. The various modifications above described tell their story in the usual accepted manner—viz.: that a positive reaction to pregnancy can be obtained in about 90% of cases if performed by a competent pathologist. The remaining 10% can usually be accounted for by some endocrine dyscrasia or other pathological lesion of known entity. This test, therefore, is of inestimable value in positively determining the presence or absence of pregnancy.

H. B. M.

A New Measurement for Estimating The Depth of the Pelvis

W. Schuman (*American Journal of Obstetrics and Gynecology*, 28:497-500, October, 1934) calls attention to the article of Caldwell and Moloy in the *Journal* of 1933 (v. 26, p. 479) on the classification of the female pelvis. As pointed out by them the android and anthropoid types of pelvis are of frequent occurrence in this country; these types of pelvis corresponding to the male or funnel pelvis or high assimilation pelvis of the older classification are undoubtedly "responsible for many unanticipated dystocias." The most important characteristic of this type of pelvis is its increased depth. Yet neither the usual external pelvic measurements nor modern X-ray pelvimetry allow for a definite measurement of the depth of the pelvis. The author proposes a new measurement, made with the ordinary pelvimeter, from the tuberosity of the ischium to the iliopectineal line. This measurement is best made after the intertuberous diameter has been measured, keeping one end of the pelvimeter on the tuberosity, and swinging the other end to a point on the upper border of the superior ramus of the pelvis "directly perpendicular to the tuberosity." Allowance of 1 cm. for the soft parts should be made in patients of normal build, and of 2 cm. in obese patients. The average measurement the author has found to be 11.5 cm., giving a "true bony perpendicular" of 10.5 cm. While this measurement has not been made in a sufficient number of cases to determine its value in prognosticating dystocia, it is now being used as a routine in the author's service in the Sinai Hospital of Baltimore; and he suggests its use by other obstetricians in order to determine its usefulness.

COMMENT

Pelvimetry as usually practiced is not very accurate. "Practice makes perfect" does not apply here for, while practice makes for better pelvic measurements, no one could ever attain perfection in this work. The "personal equation" element must ever be considered. The author's instrument for measuring the depth of the pelvis may be helpful (we have not used it), but we believe that sooner or later "personal pelvimetry" will give way to x-ray pelvimetry, which is entirely "impersonal" and hence more accurate. "Too complicated," says the average obstetrician! Yes, right now, perhaps. However, we believe that within a very short time the x-ray method will be so simplified that any roentgenologist-obstetrician (one or both) will be able to measure the pelvis with an accuracy that is un-

(Concluded on page 64)

Editorials

Takata-Ara Test in the Diagnosis of Liver Disease

A reliable liver function test is quite welcome. Clark W. Heath, with the technical assistance of Elizabeth King (*New England Journal of Medicine*, December 13, 1934), points out that the Takata-Ara serum reaction is not well known in this country and "appears to deserve some recognition, not only as a diagnostic aid, but also as an advance in the knowledge of the physiology of the liver."

These workers show that the method of testing the serum is simple to perform and that it is a specific liver function test, although it does not seem to run parallel with other liver function tests and seems to bear no relationship to the degree of jaundice. They believe that it is useful in the diagnosis of obscure abdominal conditions in which there is a question of liver cirrhosis or severe liver damage. If the test is performed on ascitic fluid it is of value in determining the presence of cirrhosis.

Heath and King found that the serum reaction was positive in sixty per cent of seventy-seven cases of liver cirrhosis and also in certain cases of marked liver damage. It was positive in almost all cases of advanced liver cirrhosis. The reaction was positive in less than three per cent of 376 general medical and surgical cases in which there was no definite evidence of liver damage.

In practical use, Heath has found that the test helps in such problems as differentiating the hematemesis of ulcer and that of ruptured esophageal varices in cirrhosis, and in the diagnosis of obscure cases of jaundice in which the question of cirrhosis, cholelithiasis or malignancy has arisen. Like most other laboratory procedures, complete reliance is not to be placed on the test. It gives presumptive and corroborative evidence. He states: "The determination of the changes of the colloidal states of the serum proteins, in liver diseases which have to do with the Takata-Ara reaction, should aid to advance knowledge in the chemistry of the blood and the physiology of liver function."

It is rather unfortunate that the test can only be relied upon in advanced cases of cirrhosis. However, this is an extremely important thing.

M. W. T.

The Criminal Type

We had supposed that the criminology or psychiatry which taught the theory of psychopathic criminal type stigmata, *à la* Lombroso, had passed into limbo; but lo and behold, the celebrated trial in New Jersey resurrected once again an alleged significance in flappy ears, deeply set eyes, and a flat head.

Partly upon these findings we have again been asked to believe by this school that a noted defendant stood practically convicted when first arraigned at the bar of justice. Upon certain physical—fea tural—traits he was adjudged potentially capable of the meanest of crimes. It would seem almost as though he, or anyone like him, should, on these principles, be summarily and economically dealt with by society coincidentally with indictment. We should hate to see such a theory applied right and left—the Salem witchcraft delusion would be completely outdone.

Starting with these assumptions, an accused person fitting the ideas of the "criminal type" school is personally identified with every detail of a crime and exploited accordingly in the ballyhoo wing of the press.

It would never do for some of our best citizens to be unjustly accused of criminal acts, if this school possessed any authority. We are thinking particularly of one of America's most distinguished gynecologists, now dead, who, on the Lombroso principle, would have received short shrift if he had ever had the misfortune to fall under suspicion in connection with a crime. And we recall how a noted criminologist, asked to classify the crooks shown to him in a collection of portraits, picked William Dean Howells as "a second-story man"—Howells' portrait having been placed as a test among the others.

To this school but little meaning is inherent in the world's cockeyed economic system. We would be naive indeed if we looked only at the criminals and never at the pillars of society, themselves licensed to racketeer, whose activities breed what is substantially emulative but unprivileged crime.

Of course, our respectable gangsters and swindlers never have flappy ears, deeply set eyes, or a flat head.

If by the time this editorial is published Hauptmann has been convicted, it will have been for good reasons and not because he has flappy ears.

The English Utopia

Recent propaganda for health insurance in the tabloid press stresses the point that the English system does not interfere with private practice. The practitioner conducts his private practice as before and his insurance income is just so much velvet.

What is the fact? Doctor R. G. Leland, Director of the Bureau of Economics of the American Medical Association, writes on this very point in the January issue of the *Bulletin of the Medical Society of the County of Kings and Academy of Medicine of Brooklyn*. What he says follows: "These physicians [in England] still have some private practice, but proposals now being considered to extend that system [the insurance system] will further restrict this field of independent private practice."

Thus tabloid propaganda tells the truth, but not the whole truth. The motive is plain enough.

Hospitals Changing With the Times

As private philanthropy and charity wane, institutions supported by them in the past fade before our eyes, and former professional welfare workers appear in new regalia, for as the old ship sinks the crew leap to the new craft, government sponsored and bound for a paternalistic gold coast.

Heavily raised inheritance and income taxes (not to mention a possible capital levy) may, it appears, release the poor from dependence upon the bounty of the rich and provide jobs for all the erstwhile charity workers.

What of the hospitals which were once upon a time so beholden to the philanthropic Babbitts of the land, and with which our own interests have been or are so indissolubly intertwined? To what extent will the scheme, now in process of adoption, aiming to insure private hospital care at low premiums—and other devices—reduce deficits?

Will the hospital of the future tend more and more to be an instrument of government, like the school system, and not so much a private product of rugged individualism?

The handwriting upon the wall is dim but not wholly illegible.

Lottery Possibilities

By nature, Americans are born speculators. Why not take advantage of this fact and have Federal government, state and city lotteries, mostly in the interest of the sick? Other countries have had these for years. There will be some opposition to this plan, especially from those professional puritans who have been trying for a long time to make us a hypocritical, bourgeois-minded, mediocre and ridiculous nation.

The matter deserves the more consideration in these times, when the sources of the wealth that once flowed into our hospitals are not so much dried up as selfishly withheld. M. W. T.

Miscellany

England's Union Doctors

When the British doctors' union joins up with the Trades Union Congress it does not mean that the medical profession will be radicalized by association with the organized industrial workers. If anything, the chances are the other way about.

The Trades Union Congress in Great Britain, like the American Federation of Labor here at home, is a stronghold of anti-revolutionary doctrine. It stands for the policy of Gradualism. The advocates of speedy and drastic social change are chiefly among the intellectuals of British Labor. The red tinge is much more likely to be found in an English doctor than in an English miner or locomotive driver.

Not that the organized medical profession inclines to militancy. The secretary of the Medical Practitioners Union, whose near 4,000 members have affiliated with the Trades Union Congress, says that the union's rules forbid strike tactics directed against the sick. This doctors' organization is nearly twenty years old and in all that time it seems to have been faithful to its principles.—*New York Times.*

A Statement by President Roosevelt on Responsibility for Care of the Sick

A significant statement made by the President of the United States appears in a letter, which it was announced on December 11 he had sent to David H. Pyle, president of the United Hospital Fund in New York City. The letter was an endorsement by the President of a campaign for $500,000 toward the free work of fifty-six voluntary hospitals.

In his opening paragraph the President said:

"While the Federal Government has necessarily stepped in to aid the states and localities in providing relief for the needy unemployed in their homes, it is impossible to make government funds available to the hospitals for the care of the sick who lack funds to pay. Yet such patients are among the most needy of all the victims of unemployment. *I have repeatedly stated my feeling that the care of the sick is a local responsibility.* All over the land communities are rising manfully to fulfil this obligation.

The italics are ours.

—*J. A. M. A.*, Dec. 22, 1934.

Correspondence

Relief of Surplus Population

To the Editor of the
MEDICAL TIMES AND LONG ISLAND MEDICAL JOURNAL:

In the December number of the MEDICAL TIMES AND LONG ISLAND MEDICAL JOURNAL Doctor Thewlis says that the world is overpopulated. I do not like to dispute a colleague of the same faculty, but when Harvard University placed James and Münsterberg on opposite sides of philosophical questions it painted the lily for Harvard. In that category I am painting the lily for the MEDICAL TIMES. Incidentally, when Münsterberg was to dine with me at the club (Metropolitan) in New York one day a philosopher whom I asked to join us preferred not to do so on the ground that he would never agree with Münsterberg—All that I had planned was for a dinner that would agree with all of us.

The world can never become overpopulated so far as we know because of several reasons for which there is no room in this letter but which will be detailed in my newest book which is now in press. The realtor must gradually disappear like other monstrous creations of the past. There is room for all of the surplus populations of the East right here in America but not on the philosophy of sandlots orators of our West. Malthus like Dick Deadeye meant well but he didn't know. When saying that there is room here for surplus populations I am not speaking politically but only as a social primate, of which *Homo* has said that it is the highest. That is a question for the debating society. When a monkey makes a tool it is for purposes of mischief. It breaks off a stick of just the right length to push a colleague off from a comfortable perch, or to pull his raisins over to another heap for dinner. *Homo* makes

more elaborate tools but they are all in the end for mischief—pulling the goods of colleagues all over to his own heap—and pushing them off from comfortable economic places.

The world now raises so much food and clothing material that these cannot be used locally or profitably exchanged in trade—*Homo*, the highest primate, in the course of its mischief kills off others of the species that are necessary for purposes of the trade—an old cat knows better than to do anything of that sort—ergo, *Homo* is of lower intelligence than *Mus rattus*.

Sandlot oratory would not allow the Chinese with many centuries of civilization back of them to add culture to that of the sandlots.

I have gone professionally with Chinese court interpreter Charles in New York to where wives were treated as pets and in the same quarter have sent for the ambulance to take the victim of a Christian wife beater to the hospital for removal of her dead baby.

Going back to the question of overpopulation — the reason for civilizations all getting to Nietzsche's Sodom and Gomorrha as described by Flinders Petrie and other historians was not well known at the time when you gave us the allegory of the orchid blossoming with such wonderful beauty while the roots were dying. In my "Surgeon's Philosophy," now out of print but in libraries—published in 1915 by Doubleday and Page—I made another picture illustrating the same thing—the double rose (see my index) means that sex organs are going over into a display of beauty. This explains the beauties of human expression in art in its broad meaning at the time when genius brings a family history to a close. In my Surgeon's Philosophy I laid down the postulate that the logical end of culture is the elimination of any race among plants and animals. This is in accordance with the Bible (Sodom and Gomorrha) and also in agreement with the modern conception of life being only a colloid incident in the chemistry of plants. I give detailed explanation in my new book and this must go as a simple statement of fact in a short note. Briefly, the primate which named itself *Homo sapiens* when no one was looking expands the tools which the monkey makes and uses for purposes of mischief into gun and sword for a larger mischief but with the same ultimate purpose.

Public enemy No. 1 connotes a direct murderer. Public enemy No. 2 is he who tells us that the world is overpopulated. "Disciples" quote him for their nefarious destruction of marshes and forests.

Yours truly,
ROBERT T. MORRIS.

140 East 54th St., New York.

To the Editor of the
MEDICAL TIMES AND LONG ISLAND MEDICAL JOURNAL:

Apropos of Doctor Morris's letter, I should like to make the following remarks.

Two outstanding morons tried to get married in a New England town. The local clergymen objected. The love-lorn pair could not get a license near home, where their mental flaws were known. They had better luck in the next township (someone once said that a law prohibiting spitting in Rhode Island didn't matter, since, with a little practice, one could spit over into Massachusetts).

They're married and we presume they are not interested in birth control. We admire the common sense and civic concern of the clergymen who balked at the prospect of wishing a few more half-wits on their home town, and we are sorry they could not prevent confrères from performing the ceremony.

Some time ago we were rather startled when told that a theretofore harmless farm-hand had shot a State trooper, and been shot in turn by the State police. We had often spoken to this man, and had always considered him a moron, but could not imagine why he had run berserk. We soon found out. He had always played the drum in the Memorial Day village parade. He had done so for some fifteen years—and now, someone else had been given his drum.

The moron's back went up, he let out his claws, someone called the police to stop a brawl and, half an hour after, the police were reckoning the cost: two corpses, that of a young trooper, and that of the half-wit, shot down like mad dogs.

They are dangerous, those who straddle the thin line which psychiatrists have drawn between sanity and insanity—an arbitrary line at best. If we realize that the sane are certainly not sane all the time, and the insane often sane half the time, we have something to worry about and keep us awake until the first streak of dawn!

And we are overwhelmed by a sense of responsibility towards those who may become the victims of morons.

We are not dramatizing. We do know that to outbreed faults takes more than new blood—it takes just the right outcross. To correct certain physical defects in animals seems easier than to eliminate psychopathic characteristics, such as shyness. A shy strain is the dog-fancier's nightmare. It is unreasonable to think that faults are likely to stick just as fast and long (and "throwbacks" just as likely to occur, after one or two generations of normal specimens) in humans as in dogs? And what every dog breeder does know is that a shy dog is hardly ever quite safe. If scared out of its wits, it may turn on you.

There is, to us, a strange similarity between the mental reactions of the shy dog who bares his fangs at you while crawling under the sofa and a certain type of criminal.

The shy dog thinks the world at large is inimical; the social misfit who is wrapped up in self-pity, obsessed with the idea that he or she is getting all the bad breaks, and bent on getting even with society for imaginary dirty deals, is familiar to most of us. We contrast him with the originally sound human being who has been so bludgeoned by fate that he has become warped. The latter can usually be redeemed, is responsive to kind treatment, has a streak of decency, and no matter how low he has fallen, sticks to certain broad human rules.

The former is a mental case, and should be in the hands of specialists. In a country already overpopulated, why allow mental deficients or the mentally abnormal to propagate themselves? If they must marry, let them be castrated or spayed. Their offsprings are likely to inherit the distressing characteristics of sire and dam, and transmit them to their progeny. How long it will take to outbreed them no one can tell. In the meantime, such people will be driving automobiles into fences and other peoples' machines, shooting others when they feel like it, trying in vain to adjust themselves to life and, in the process, scrambling things up and occasionally dragging others into tragedies.

It is estimated that our population will be 140,000,000 in 1970 and about 75,000,000 in the year 2000. Not such a bright outlook. The steady increase of efficiency methods and labor-saving devices should convince us that the birth rate must fall off, or we may face disaster. The *Lancet* states that, in Great Britain, there will be a decrease of 11,000,000 in 1976. The birth rate is dropping rapidly and the United Kingdom's problem has solved itself.

Why not attempt to check this dumping of children on a weary world where there is no room left except an unwholesome or dreary spot where they wouldn't stand a chance to develop normally? True enough, there are vast empty areas where humans could thrive, but have you stopped to think that such areas are not available, that they may not be colonized, that they may not be exploited yet, and that they belong to others, or are within their sphere of influence? When a nation muscles in on another's racket, what happens? What political tangles would follow the mere suggestion that a crowded nation intends to dump its surplus population on blank spots in someone else's territory or close to it? Try it. There is only one no-man's land, and that is the strip which stands between trenches when the slaughter has begun.

What we should endeavor to eliminate is the tenement house, the soul-searing circumstances which warp human nature, and lack of elementary comfort, medical attention and proper food, all of which tend to swell the already impressive army of crime.

That those least able economically to care properly

for children should be the very ones who are often denied a thorough knowledge of birth control methods seems cruel and absurd.

The Ogino-Knaus contribution may be an important addition to our means for controlling population but the mentally unfit are beyond reach. We cannot hope for self-control amongst them; we can never instill any sense of responsibility towards others in infantile brains or in those marred by psychopathic streaks.

MALFORD W. THEWLIS.

Wakefield, R. I.

Personality and Emotional Factors in Reactive Negativism

To the Editor of the
MEDICAL TIMES AND LONG ISLAND MEDICAL JOURNAL:

In the December issue of the MEDICAL TIMES AND LONG ISLAND MEDICAL JOURNAL there appeared an exceptionally well-written article entitled "Personality and Emotional Factors in Reactive Negativism," written by Delmer Dennis Durgin.

Dr. Durgin is evidently a psychologist as well as a doctor of medicine, and it is because his essay so pertinently indicates the present tendency of the medical profession to depart from the terra firma of material facts and seek the answers to their professional problems in the ethereal realm of synthetic conjecture that I make bold to criticize his thesis.

It seems to me that the old definition of the science of metaphysics—"that portion of mental philosophy which attempts to determine what part of the furniture of the mind belongs to it originally, and what part is constructed out of materials furnished it from without"—will also serve definitely to define the newer science of psychology.

And as long as psychologists confine themselves to these limitations their science is scientific. But when they propose—as so many of them do, nowadays—to graft psychology onto the curriculum of a doctor of medicine they place themselves outside the pale of rational science and into that limbo of cultists which includes the names of Mrs. Eddy and John Alexander Dowie.

Synthetic reasoning is safe, sound and scientific up to a certain point only, and there inevitably comes a branching of the trail, leading on the one hand back to a paralleling with empiric fact, and on the other into that nebulous domain which John Stuart Mill designated as "that fertile field propagated by language." And there we lose ourselves in a maze of our own making.

For instance, Dr. Durgin says that a schizoid is an introvert, and a syntoid an extrovert. The word schizoid derives from the Greek, of course, and it means "something which is split into two parts." Syn is a Greek prefix denoting "along with, together, at the same time." Introvert means to look within, while extrovert is to turn out, or toward outer things.

To say that one is an extrovert or an introvert is to say that one has a certain definite and specific kind of mental habit. But if you declare that an individual should be classified as a syntoid or a schizoid it seems to me that you imply a "split" mental habit, or two different mental habits which exist together at the same time.

Probably psychologists really know at all times just what they mean, but if they do, it is unfortunate that their technical language is often so inept and contradictory that it utterly fails to convey any concise meaning.

Moreover, their synthetic conclusions often seem quite contradictory to material fact. Dr. Durgin says: "The schizoid (introvert) person is biologically immature, imperfect morphologically and probably suffering from a specific type of cerebral defect." And he alludes to extroverts (syntoids) as a "well balanced, harmonious type."

Now, I take it that the ultimate measurement of any individual is whether or not society as a whole has been benefited or harmed by that individual's existence. And on this basis we must give the introvert a much higher rating than the extrovert.

For on the one hand we have our Newtons, our Harveys, our Shakespeares, our Poes, our Edisons and our Wrights, while on the other we have our "Jimmy" Walkers and our "Big Bill" Thompsons.

May I submit that the brain is a coordinate part of human anatomy, just as are our great toes. It comes into being, it is nourished, and it has certain functions to perform just as other parts of our anatomy. One of its functions is the production of thought, just as one of the functions of the liver is to produce bile. If the liver ceases to produce bile of a proper quantity or quality, we seek a method or means of restoring normal function in our knowledge of physiology, biochemistry and pharmacology. If the thought-producing function of the brain becomes weakened or distorted let us seek our remedy within the realm of medicine and her sister sciences, rather than in the "mumbo-jumbo" of conditioned complexes and reactive negativisms.

Let us, in our professional thoughts and contacts, remember that the practice of medicine is a material science dealing with material things, and by so doing we will increase our skill and perpetuate the honor and glory of our profession.

A. M. ALLEN, M.D.,
Director of Medical Research,
Blue Line Chemical Company,
St. Louis, Missouri.

Contemporary Progress

(Concluded from page 60)

believable today. X-ray pelvimetry should be the next important landmark in obstetrics.

H. B. M.

The Residual Tube Following Ectopic Pregnancy

I. C. Rubin (*American Journal of Obstetrics and Gynecology*, 28:698-706, November, 1934) reports an examination of the residual tube by tubal insufflation in 90 cases after an ectopic pregnancy; in most of these patients (74) the examination was made more than two years after the ectopic pregnancy. Only 12.35 per cent. of the 90 tubes were found to be normally patent; 43.21 per cent. were completely obstructed and 44.44 were partially obstructed. Of 23 patients who became pregnant again without treatment, 7 showed a normal patency of the residual tube; of the 67 patients who did not become pregnant without treatment, only 6 showed normal patency of the tube. Twelve patients became pregnant after insufflation; in 8 the pregnancy was uterine; in 4 another tubal pregnancy occurred. As a rule if the pressure at uterotubal insufflation was about 100 mm. Hg mercury, the following pregnancy was uterine; if the pressure was above 150 mm. Hg, indicating marked stricture, it was tubal. Repeated insufflation may improve the status of the tube and favor normal pregnancy. The author concludes that "intrauterine pregnancy occurs with sufficient frequency after an operation for tubal pregnancy to encourage conservation of the residual tube. . . . The age of the patient, her parity and her desire to bear more children should influence and determine the procedure."

COMMENT

Rubins' work on the determination of the patency of the oviducts is well known and highly commendable. While the Rubin test for tubal patency has been much abused by the unscrupulous practitioner it, nevertheless, remains an important and reliable test when properly used in selected cases. By this method the patency of the residual tube following ectopic gestation can be determined. The frequency of intrauterine pregnancy through such tubes is of sufficient frequency to stimulate the operator to conserve more of these ectopic tubes than would otherwise be the case. The age of the patient or the great desire to bear children should determine the procedure in each case. It is worthy of trial.

H. B. M.

DR. WILLIAM J. MAYO:—The most dangerous driver on the road today is not the drunken driver; it is the driver who has had only one or two cocktails on an empty stomach.

Some doctors are charging excessive fees at a dollar an office call.

MEDICAL BOOK NEWS

Edited by TASKER HOWARD, M.D.,

All books for review and communications concerning Book News should be addressed to the Editor of this department
1313 Bedford Avenue, Brooklyn, New York

February, 1935

CLASSICAL PARAGRAPHS

In my reflections on the subject of rest as a curative agent, my mind naturally reverted to that period of man's existence when it was the sole curative means of which he could avail himself. I could but picture to myself the timorous awe which must have been engendered in his mind by the first accident which happened to him. Let us imagine our first parents suddenly thrust out of the garden of Eden, and doomed to toil for their daily bread; with hands unused to labor, inexperienced in the substitutes for unnecessary exertion and in the avoidance of local injury, and exposed to all the accidents of a precarious existence. Let us try to realize the awe-stricken dismay which must have oppressed man's mind on the infliction of his first wound, his first experience of pain;—the breach of surface disclosing to his sight his blood flowing unceasingly, or leaping at sustained intervals, from its opened chambers, his sense of fainting, and his ultimately sinking on the earth under the foretaste of death; this, too, with the recent denunciation, "Thou shalt surely die," still ringing in his ears. Can words depict the hopeless anguish which he must have endured? But what follows? See him awakening to life again, the stream of blood stayed, the chasm plugged, his strength revived, and day by day that wound—which he regarded as the badge of death, the vengeance of the Creator's wrath—narrowing and healing till it could hardly be seen.

John Hilton. *On Rest and Pain. A Course of Lectures on the Influence of Mechanical and Physiological Rest in the Treatment of Accidents and Surgical Diseases, and the Diagnostic Value of Pain. Delivered at the Royal College of Surgeons of England in the Years 1860, 1861, and 1862. London. American Edition, New York, William Wood and Company, 1879.*

REVIEWS

Applied Anatomy

APPLIED ANATOMY. By Gwilym G. Davis, M.D. Philadelphia, Ninth Edition. Edit. by Geo. P. Muller et al. J. B. Lippincott, [c. 1934]. 717 pages, illustrated. 4to. Cloth, $9.00.

The first edition of this work was brought out about 25 years ago by the late Gwilym G. Davis, and during the succeeding years new editions were printed, with revisions, keeping this text up to date.

This, the Ninth Edition, has been entirely revised, reset and reillustrated, and although the B.N.A. nomenclature has been supplemented, it is not used exclusively.

This book has always been a popular one for the student and this new, revised edition will undoubtedly increase its popularity in the teaching field.

The Anatomical Structure and Its Relation to Function idea, of the original work by the late Dr. Davis, is maintained throughout this edition. The subject matter is taken up not by chapters, but by structures of the body, starting with the scalp and finishing with the foot.

The volume is profuse with illustrations, comprising a total of 674, many of which are in color. There is a total of 686 pages of subject matter, the last 15 pages being devoted to Frozen Sections, giving 26 cross section illustrations that are well labeled and covering the entire body.

If any criticism could be offered, it would be that the sympathetic relationship to structural function, is, perhaps, a bit too briefly discussed.

This volume on Applied Anatomy has been and undoubtedly will continue to be the foremost in this country, in this field of study and teaching. It is an excellent adjunct to the practicing surgeon, and it will certainly be well received by the teachers of surgical anatomy.

HERBERT T. WIKLE.

Pathology

A TEXT-BOOK OF PATHOLOGY. Edited by E. T. Bell, M.D. Second edition. Philadelphia, Lea & Febiger, 1934. 767 pages, illustrated. 8vo. Cloth, $8.50.

The University of Minnesota Department of Pathology has considerably enlarged its student text with the present revision. Cooperatively arranged through the collaboration of five members of the medical faculty, the result is an authoritative volume bringing the essentials of pathology closely in relation to clinical medicine. Especially marked in value for instructive purposes are the illustrations, original throughout, excellently printed, and nicely selected for clinical stress.

Critical analyses of the first edition have resulted in expansion but without loss of the clearly concise style of its authors. The chapter divisions of Special Pathology are well adapted to the use of the student throughout his collegiate courses. They also may well provide the practitioner with pathologic essentials in specialized fields. Both student and practitioner may utilize the references, titled for handy selection, as an introduction to further specialized literature.

While the established text-books will not be replaced by this treatise, it merits use in view of its complete field and its adaptability to clinical courses. Particularly so are the chapters on Gynecological Pathology, Neuropathology, Diseases of the Urinary System, of the Blood, and of the Bones and Joints.

IRVING M. DERBY.

Medical German

ENGLISH-GERMAN and GERMAN-ENGLISH MEDICAL DICTIONARY. By Joseph R. Waller, M.D., and Moritz Kaatz, M.D. Fourth Edition, First Part. English-German. Leipzig and Vienna, Franz Deuticke, 1934. 201 pages. 16mo. Cloth, M. 6.

This little dictionary consists of Part I, German and English. It is the fourth edition, "newly edited" by Dr. Adalbert Springer. He has added many new "expressions" and has omitted Latin terminology, in order to avoid increasing too much the compass of the work. Many of the words sound odd to an American reader, as they seem to differ from our terminology. For the same reason it does not appeal strongly to us as a fully helpful pocket dictionary. On the other hand, it is interesting as a comparison between the English and American modes of expression.

J. M. VAN COTT.

Gynecology

A TEXT-BOOK OF GYNECOLOGY. By Arthur H. Curtis, M.D. Second Edition. Philadelphia, W. B. Saunders Company, 1934. 493 pages, illustrated. 8vo. Cloth, $6.00.

Truly a text-book of which the author may be proud. One who casually scans the volume will be impressed by the artistic illustrations. Not alone are these artistic but they vividly portray the more common gynecologic conditions as well as operative procedures. Of the latter those of the plastic operations are most descriptive.

The subject matter is well covered and as thoroughly as one would expect in a work of this nature. Void of extraneous matter and easily read, the student will find it of great value. It is more than an introduction to the subject and will provide material for thought as to the importance of attention to detail especially in operative technique.

Based upon his own extensive experience the author is well qualified to venture sound opinions as to diagnosis and treatment.

WM. C. MEAGHER.

Therapeutics

MODERN TREATMENT IN GENERAL PRACTICE. Edited by Cecil P. G. Wakeley, D.Sc. Baltimore, William Wood and Company, 1934. 426 pages, illustrated. 8vo. Cloth, $4.00.

A series of short practical articles on Treatment appearing in the Medical Press and Circular proved so popular that they have been collected in one volume and are now brought to this country by William Wood and Company. The Preface quotes a friendly editor who remarks of them: "It must be a very rare occurrence for a practitioner not to find in each number something of immediate practical importance to him." Approached from this standpoint they no doubt have much to offer but they are too brief to serve as a satisfactory guide to treatment. The papers average something less than eight small pages each. The fifty-six subjects covered consist in a miscellaneous selection including medicine, minor (and some major) surgery, and most of the specialties. A few of the authors are of international reputation, but the names are mostly new to us and it is a pleasure to make their acquaintance through these brief, sound, papers on treatment.

TASKER HOWARD.

Psychoanalysis

FACTS AND THEORIES OF PSYCHOANALYSIS. By Ives Hendrick, M.D. New York, Alfred A. Knopf, 1934. 308 pages. 8vo. Cloth, $3.00.

This is an excellent book for layman and physician alike. To those interested in obtaining a general idea of what psychoanalysis is this book can be highly recommended. The author begins with a lucid exposition of Freud's conception of the unconscious. He then treats briefly of the significance of dreams as unconscious wish-fulfillment. The chapter on psychosexuality contains a discussion of the various phases through which the individual passes in his sexual development from childhood to maturity. Another chapter takes up the consideration of the Instincts, of the pleasure and reality principles and of the libido theory. A very fine discussion of the strucure of the personality, the id, ego and super-ego, follows. There are chapters on the technic of the psychoanalytic method and on the schools set up by Adler, Jung and Rank. Psychoanalysis is an epoch-making discovery, and no physician should fail to get informed on this subject.

JOSEPH SMITH.

Contraception

NATURE'S WAY. The Fertile and Sterile Periods of Marriage. By Victor C. Pedersen, M.D. New York, G. P. Putnam's Sons, 1934. 81 pages. 16mo. Cloth, $1.00.

An attractive little volume which presents the new knowledge of the sterile and fertile periods of the menstrual cycle. It is intended to appeal to those who "refuse the unseemly practices of artificial means" of birth control. This is a well put and laudable motive, for certainly the studied mechanics of artificial birth control are, to say the very least, unseemly.

Written for the laity, it is, however, a very practical text for those physicians who wish this important matter clarified and discussed accurately and without prejudice. The basis of Pedersen's work is the well known researches of Knaus and Ogino: their practically identical conclusions are well stated and compared in the text. An excellent table of comparisons of the different methods of determining the time of ovulation is a valuable addition to the book. Discussion of the laws of Moses and the Jewish period of separation after menstruation is very interesting and germane to the subject.

The physician will find the appended bibliography valuable. Though not a scientific book, it is biologically correct and no scientific fault may be found with it. Not at all like the other books on this subject which have appeared recently, it is by all odds the best—a simple, sound presentation like other books by the same author.

CHARLES A. GORDON.

Manometry

MANOMETRIC METHODS AS APPLIED TO THE MEASUREMENT OF CELL RESPIRATION AND OTHER PROCESSES. By Malcolm Dixon, Ph.D. New York, The Macmillan Company, 1934. 122 pages, illustrated. 12mo. Cloth, $1.75.

Our knowledge of tissue respiration and cell metabolism has come as a result of the development of manometric methods. Dr. Dixon has collected these methods in this little volume which will, in the future obviate the necessity of any one's needing these methods for physiological research, from having to resort to numerous scattered and frequently inadequate methods in the literature. It is essentially a laboratory handbook, giving not only an account of the apparatus, but also the theory of its physical basis.

A large amount of accurate information has been obtained with manometers in the investigation of the respiratory activities of organs and tissues. Its importance is already being felt in its application to medicine, particularly in the field of cancer, renal disease, hyperthyroidism and diabetes.

This book is of inestimable value to the researcher planning investigations in cell metabolism.

WILLIAM S. COLLENS.

Heart Disease

PRACTICAL TALKS ON HEART DISEASE. By George L. Carlisle, M.D. Springfield, Ill., Charles C. Thomas [c. 1934]. 153 pages. 8vo. Cloth, $2.00.

There is a strong appeal in this series of lectures to the general practitioner about heart disease. Their simplicity and sincerity reflect the influence of at least one of the three teachers to whom the book is dedicated, Cabot. Perhaps students of the other two would feel that the teachings of these men of Texas were as evident. The author believes that heart disease is seldom difficult to diagnose correctly or to treat, and that general practitioners should be competent to attend to this

without the aid of specialists or special apparatus. He undertakes to tell them how to do it and in the main his teaching is sound and easily understood, but it is perhaps too brief and in too many particulars it departs from generally accepted opinion. Thus, he states that a palpable spleen and petechiae in the conjunctivae are common in rheumatic endocarditis: that lemon yellow is the typical complexion of patients with viridans endocarditis and that the skin manfestations of this disease are as a rule very painful: that syphilis is a common cause of heart block: that the routine treatment of angina pectoris is plenty of morphine and two months in bed: that auricular flutter is prone to occur in normal hearts (or that is the implication). No mention is made of the relationship between flutter and fibrillation and the kind of hearts in which they both occur is largely left to the imagination. Arteriosclerotic heart disease he recognizes by the pressure of a large heart, lacking valvular disease or hypertension, and so on. If these rather numerous errors were corrected, or perhaps proved to be no errors, the book could be highly recommended.

TASKER HOWARD.

Autonomic Nervous System

THE AUTONOMIC NERVOUS SYSTEM. By Albert Kuntz, M.D. Second edition. Philadelphia, Lea & Febiger, 1934. 697 pages, illustrated. 8vo. Cloth, $7.50.

This standard textbook of the anatomy of the autonomic nervous system has achieved a just and widespread popularity in the medical schools and libraries of the country. The second and enlarged edition will doubtless further entrench the author as the pioneer teacher of this subject. Although the approach is primarily an anatomic one, the divers sections of autonomic action are recapitulated in physiologic, pathologic and surgical chapters. Unfortunately, the exhaustiveness of the book as a whole is not carried through in the sections on the clinical and functional manifestations of autonomic syndromes. Although the author excuses his inability to compress all the multitudinous material into one book, we feel that a slightly greater stress on this side would have made the subject somewhat more alive for the student. As a reference book, however, it leaves little to be desired, since practically every important detail of the field is considered and there is an unusually voluminous bibliography for each chapter to satisfy even the meticulous student of special subjects. The whole is topped off with a complete index.

SAM PARKER.

College Hygiene

HYGIENE FOR FRESHMEN. By Alfred Worcester, M.D., and Henry K. Oliver. Springfield, Ill., Charles C. Thomas [c. 1934]. 151 pages. 8vo. Cloth, $1.50.

The title—"Hygiene for Freshmen"—would lead one to expect a reformation and humanization of this notoriously dull college subject. But as we peruse the pages of this book, we find information that is thoroughly reliable, but quite impersonal. Not even a picture to excite the imagination or to clarify the text. There is little to distinguish it from other standard textbooks on elementary hygiene, except that it is devoid of valuable illustrations. And the questions following each chapter seem to further detract from the apparent purpose of the book—"to stimulate an interest in hygiene"—by keeping the student constantly reminded of examinations.

EMANUEL KRIMSKY.

Child Care

THE CARE AND FEEDING OF CHILDREN. By L. Emmett Holt, Jr., M.D. Fifteenth Edition. New York, D. Appleton-Century Company, Inc., 1934. 259 pages. 12mo. Cloth, $1.25.

In this 15th edition the main changes consist in the simplification of the milk feeding. For the infant a few formulae have replaced the many formerly given. The tendency to give processed milk instead of fresh milk is stressed, though there are still many who believe fresh milk the best form.

The question and answer system have been followed throughout the book, except for the charts and tables.

The index is complete, and there is a space at the back for individual memoranda.

Part I on The Care of Infants takes up the weight, growth and development, and many details like bathing, the care of the genital organs, eyes, mouth, skin, etc.

Part II on Infant Feeding emphasizes the importance of maternal nursing, and deals with artificial feeding, and what to do when there is loss of appetite, vomiting, gas or colic, constipation, etc. Various substitutes for fresh cow's milk are described, including the changed milks, such as lactic acid milk and protein milk. The feeding is carried through the third year.

Part III deals with Premature Infants, and describes the maintenance of body temperature, the feeding and the prevention of infection.

Part IV takes up problems connected with Older Children, such as growth, training in health habits, diet, eating, and indigestion.

Part V, Miscellaneous, has discussion of constipation, sleep, exercise, rupture, the nervous child, toys, kissing, foreign bodies, contagious diseases, preventive measures, scurvy, rickets, tonsils, adenoids, taking cold, and many others.

After more than thirty years it is still kept in the front rank of books for mothers and children's nurses by repeated revision.

ARCHIBALD D. SMITH.

Sex Education

AN INTRODUCTION TO SEX EDUCATION. By Winifred V. Richmond, Ph.D. New York, Farrar & Rinehart [c. 1934]. 312 pages. 8vo. Cloth, $2.50.

We are most enthusiastic about this volume which although titled, "An Introduction to Sex Education" and consisting of three hundred pages, is really encyclopaedic in its information.

The author has drawn from most of the worthwhile literature on the subject of "sex" and has compiled a veritable store-house of information. She writes in a most interesting manner which holds the reader as would any true and interesting story when well told. The author explains in a beautiful way so many subjects which have been made so lurid by writers of the so-called popular books on sex. At the end of each chapter are listed collateral reading and a bibliography.

This work fills a greater place than was originally intended. We do not hesitate to recommend this book to physicians, for not only interesting, useful reading, but as a source from which they may gather facts which will enable them to better answer sex questions not only to adolescents but to grown-ups.

SAMUEL ZWERLING.

Experimental Physiology

EXPERIMENTAL PHYSIOLOGY. By Sir Edward Sharpey-Schafer, F.R.S. Fifth Edition. New York, Longmans, Green & Company, 1934. 168 pages, illustrated. 8vo. Cloth, $2.20.

The fifth edition of this little book, so long and well known to teachers of animal physiology, has evidently been carefully revised. Presumably it is representative of the character and extent of the laboratory course in the subject as given in the Edinburgh medical curriculum; and though therefore necessarily quite limited in extent and detail, it serves as a reliable guide for sufficient laboratory practice to lay a sound basis for more extended experimentation.

The serial order of the observations and experiments recommended is quite excellent and the directions explicit and sufficiently explanatory. The reviewer frankly recommends it to students of medicine.

J. C. CARDWELL.

Benjamin Rush

BENJAMIN RUSH. Physician and Citizen, 1746-1813. By Nathan G. Goodman. Philadelphia, University of Pennsylvania Press, 1934. 421 pages, illustrated. 8vo. Cloth, $4.00.

This book is an excellent presentation of the biography of one of the most famous physicians of the Revolutionary period in American history.

It carefully depicts the state of the practice of medicine in America toward the end of the eighteenth century, describing fully the character of Colonial physicians and their modes of treatment. The first medical

school in the United States and the members of its faculty are considered in detail.

The endeavor is made by the author to portray the true character of Dr. Rush without any unnecessary embellishments. While he assiduously analyzes the most salient qualifications of the physician—patriot, organizer of the Army Medical Corps, and founder of both school and college; nevertheless, he does not hesitate to discuss at length his idiosyncrasies—his stubbornness and tactlessness, his inflated ego and excessive self-confidence, his inability to work in harmony with men whose opinions differed from his own.

The book, as a whole, can be accorded the highest praise. It can be read with profit and enjoyment by both physician and layman.

WILLIAM RACHLIN.

Mothers' Guide

MOTHERS' GUIDE WHEN SICKNESS COMES. By Roger H. Dennett, M.D., and Edward T. Wilkes, M.D. Garden City, N. Y., Doubleday, Doran & Company, 1934. 400 pages. 8vo. Cloth, $2.50.

One sometimes wonders about the necessity or desirability of these books, but their multitude would seem to justify them.

The authors are able and experienced and are attractive writers. The advice given is safe and supplements the attending physicians' orders. In no case, so far as observed, would it encourage improper family treatment to replace needed medical advice.

The reviewer finds his own instructions to mothers offered so identically in many instances, that he cannot do other than endorse the recommendations.

The book can be approved for the purpose, for which it is offered, to help the mother in her care of her sick child.

W. D. LUDLUM.

Public Health

PAPERS OF CHARLES V. CHAPIN, M.D. A Review of Public Health Realities. Selected by Frederic P. Gorham, Sc.D. Edited by Clarence L. Scamman, M.D. New York, The Commonwealth Fund, 1934. 244 pages. 8vo. Cloth, $1.50.

To physicians, active and interested in public health work, the name of Dr. Charles V. Chapin is well known.

From 1884 to 1931, he was Health Officer of Providence, R. I., during which time he used his power of keen observation and his research ability, to explode false methods of disease control and to develop effective public health administration measures.

His book on "Sources and Modes of Infection" published 25 years ago is still a classic. Against considerable opposition, he urged a reasonable attitude toward the relation of dirt to disease. Largely as a result of his efforts, much of the useless fumigations of dwellings after contagious diseases has been discarded. His critical analyses of public health procedures have played an important part in the proper evaluation of the various activities in this field.

During his career, Dr. Chapin wrote constantly in advocacy of his ideas and contentions. Some of these writings have been collected by his friends in the volume which is the subject of this review. This book is well worth reading not only by the public health official but by modern physicians who recognize their community responsibilities.

ALFRED E. SHIPLEY.

BOOKS RECEIVED

Books received for review are acknowledged promptly in this column; we assume no other obligation in return for the courtesy of those sending us the same. In most cases, review notes will be promptly published shortly after acknowledgment of receipt has been made in this column.

PHYSIOLOGY IN HEALTH AND DISEASE. By Carl J. Wiggers, M.D. Philadelphia, Lea & Febiger, [c. 1934]. 1156 pages, illustrated. 8vo. Cloth, $9.00.

RULES FOR RECOVERY FROM PULMONARY TUBERCULOSIS. A Layman's Handbook of Treatment. By Lawrason Brown, M.D. Sixth Edition, Revised. Philadelphia, Lea & Febiger, 1934. 275 pages, 16mo. Cloth, $1.75.

CATARACT ITS ETIOLOGY AND TREATMENT. By Clyde A. Clapp, M.D. Philadelphia, Lea & Febiger, 1934. 254 pages, illustrated. 8vo. Cloth, $4.00.

INTERNAL MEDICINE. Its Theory and Practice. In Contributions by American Authors. Edited by John H. Musser, M.D. Second Edition, revised. Philadelphia, Lea & Febiger, 1934. 1288 pages, 8vo. Cloth, $10.00.

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